



DEPARTMENT OF HEALTH & HUMAN SERVICES



**Office of Minority Health
Grantee Meeting**
Arlington, VA
June 28-29, 2004

Office of Minority Health • Grantee Meeting

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Rebecca Vargas-Jackson, M.D.

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Cathy Lins
Collaborations and Partnerships

Collaborations and Partnerships

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Cathy Lins, Senior Consultant
Development Plus, Inc.

Collaborations and Partnerships -

Health Departments and Community-Based Organizations

This workshop will cover the practical and challenging rules of collaborations between governmental and non-governmental agencies. Special significance will be placed on the mutual roles of Health Departments and Community-Based Organizations (CBOs). Participants will learn the necessary elements and processes of collaborations between agencies.

Coalition Building

- Building coalitions with people or groups means the fact that often you can do things together what no one can do alone.
- Coalitions take time and energy to develop and maintain because they involve building relationships of trust with other people or groups. Many advocates find this aspect of their work to be both the most difficult as well as the most rewarding professionally and personally.

The Collaboration Continuum



Information Sharing

Resource Sharing

Joint Ventures

Less Formal



More Formal

More Independent



Less Independent

Examples of Collaboration at Each Level

Goal	Information Sharing	Resource Sharing	Joint Ventures
To enhance client services	Distributing brochures from other agencies in your waiting room. Publishing a directory of HIV/AIDS services available in the community. Distributing the directory thru agencies.	Coordinating service schedules, such as planning on which night two agencies will do outreach activities.	Contract for a meals-delivery agency to deliver meals to residents of a AIDS hospice. Joint fundraising for and management of a volunteer training program.

Examples of Collaboration at Each Level

Goal	Information Sharing	Resource Sharing	Joint Ventures
To influence public policy	Faxing a notice to other agencies about pending state legislation on funding, including the fax numbers of key state legislators.	Convening a meeting of HIV agencies, youth agencies, and pregnancy clinics to influence an elected body (i.e., School Board Decision	Jointly hiring a lobbyist and/or public relations firm to assist in a campaign to influence legislators understanding of needle-exchange programs.

Examples of Collaboration at Each Level

Goal	Information Sharing	Resource Sharing	Joint Ventures
To improve organizational effectiveness	Through friendships and informal connections, agencies exchange personnel policies, board policies, information about receptive foundations, etc.	Joint training program for practical support volunteers. Joint negotiation for audits of two organizations with different fiscal year ends to obtain better pricing.	Joint contracting for office space, lease on office machines, etc.

Overview of the Day

Workshop 1

- Highlights of Starting a Coalition
- Factors Influencing Collaborations
- Study Focused on Working with Health Departments in Collaborations
- Creating Logic Models for Coalitions
- Evaluation of Coalitions

Overview of the Day

Workshop 2

- Best Practices and Practical Applications

Starting Coalitions

Maintaining Coalitions

Evaluating Coalitions

Collaborations and Partnerships Plenary Session

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Collaborations and Partnerships –

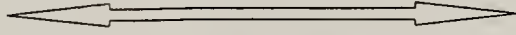
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Less Formal ----- More Formal

More Independent ----- Less Independent

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 - Maintaining Coalitions
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Collaborations and Partnerships Theoretical Elements

**Cathy Lins, Senior Consultant
Development Plus, Inc.**

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Expectations

- Cell phones on vibrate or silent.
- Be responsible for your own needs.
- Observe the quiet signal.
- Participate fully.
- Support others in participating.
- Limit side conversations.

Four Rules for Successful Collaboration

- The scope of the collaborative project is clearly defined
- Each partner knows how the collaboration will advance the interests of its organization and clients
- Roles and responsibilities have been defined; mechanisms for communication and joint accountability are in place
- The relationship “works,” there is enough trust and respect among the key players to support the level of risk and interdependence involved in the project

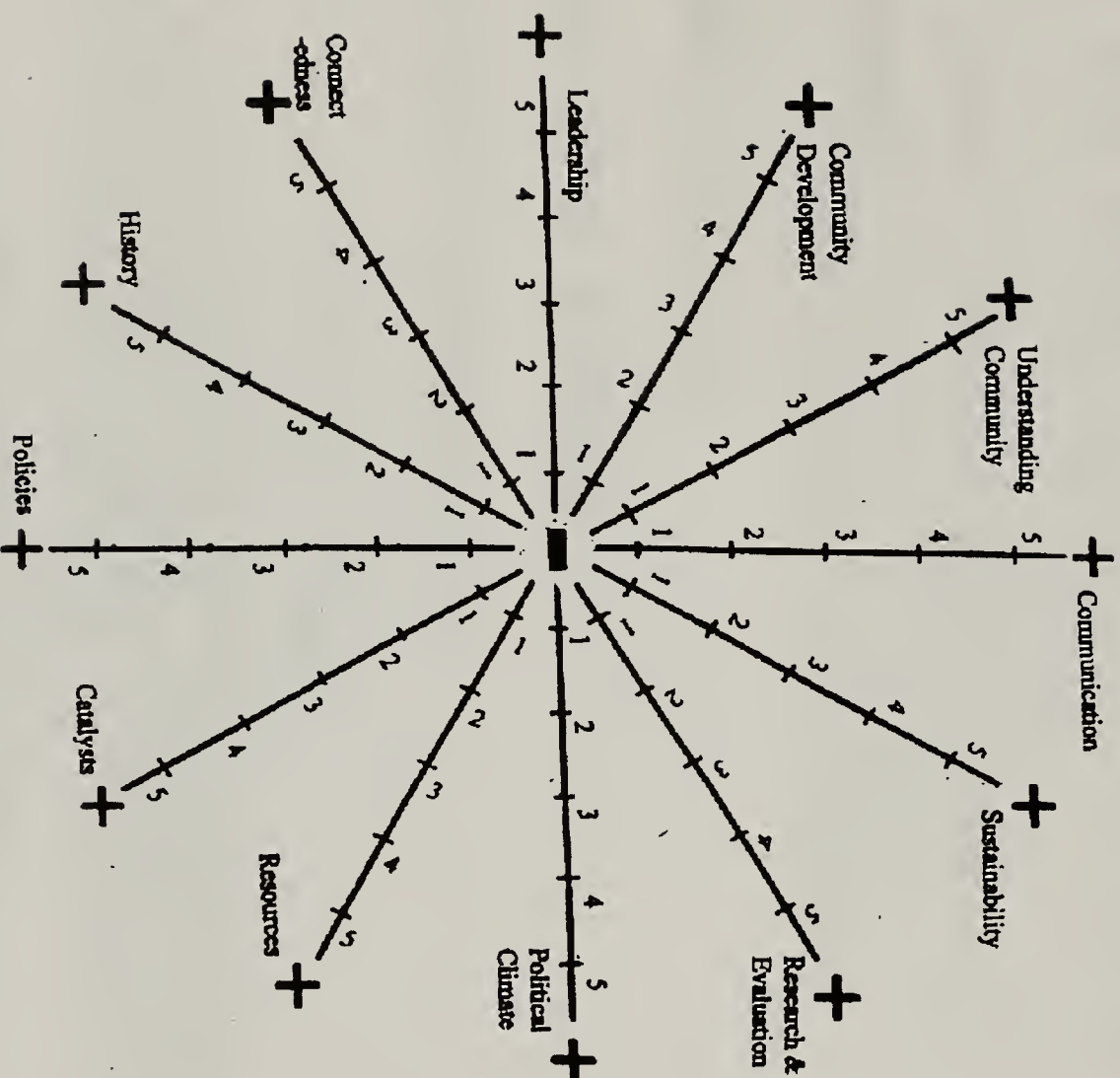
Getting a Collaboration Started

- Getting the first meeting started.
- Setting your vision and mission.
- Confirm Organizational Roles
- Resolve Conflict
- Organize the Effort
- Support the Members
- Lay Out An Action Plan
- Create Accountability Standards

Disclose Self-Interests

- Culture
- Gain
- Diversity
- Perception
- Power

Factors the Influence the Collaborative Process



Factors that Influence the Collaborative Process

- **Communication** – the collaboration has open and clear communication. There is an established process for communication between meetings.
- **Sustainability** – the collaboration has a plan for sustaining membership and resources. This involves membership guidelines relating to terms of office and replacement of members.
- **Research and Evaluation** – the collaboration has conducted a needs assessment or has obtained information to establish its goals and the collaboration continues to collect data to measure goal achievement.

Factors that Influence the Collaborative Process

- **Political Climate** – the history and environment surrounding power and decision-making is positive. Political climate may be within the community as a whole, systems within the community, or networks of people.
- **Resources** – the collaboration has access to needed resources. Resources refer to four types of capital: environmental, in-kind, financial, and human.
- **Catalysts** – the collaboration was started because of existing problem(s) or the reason(s) for the collaboration to exist required a comprehensive approach.

Factors that Influence the Collaborative Process

- **Policies/Laws/Regulations** – the collaboration has changed policies, laws, and/or regulations that allow the collaboration to function effectively.
- **History** – the community has a history of working cooperatively and solving problems.
- **Connectedness** – members of this collaboration are connected and have established informal and formal communication networks at all levels.

Factors that Influence the Collaborative Process

- **Leadership** – the leadership facilitates and supports team building, and capitalizes upon diversity and individual, group and organizational strengths,
- **Community Development** – this community was mobilized to address important issues. There is a communication system and formal information channels that permit the exploration of issues, goals, and objectives.
- **Understanding Community** – the collaboration understands the community, including its people, cultures, values, and habits.

Examples from a Prison Study

A look at public health/corrections collaborations for prevention and treatment of HIV/AIDS, STDs, and TB.

- Availability of data on disease burden or dramatic events such as outbreaks demonstrating the need for collaborations.

Examples from a Prison Study

- Organizational, legislative, or regulatory provisions such as health department responsibility for provision of health services in correctional facilities; or legislation or regulations requiring oversight mechanisms, screening, or disease reporting.

Examples from a Prison Study

- Attitudes and philosophies such as commitment to collaboration at agency and facility levels; correctional agency willing to open its facilities to outside organizations; and mutual sensitivity to concerns, priorities, and perspectives of corrections and public health personnel.

Examples from a Prison Study

- Health department funding of programs in correctional facilities and operational features such as the presence of health department personnel in correctional facilities, liaison staff in correctional and public health agencies, formal agreements for collaboration (such as MOUs) and long-standing interagency relationships.

Examples from a Prison Study

- Communication and information exchange such as correctional representation on HIV Prevention Planning Groups, service on joint committees, regularly held meetings at leadership and operational levels, and the exchange of important information about patients.

COLLABORATION FRAMEWORK

- Public Safety

- Education

- Economic Wellbeing

OUTCOMES

IMPACT MEASURES

- Real People Impacts

- Policy Development

- Systems Development

- Resource Development

- Family Support

- Health

- Environment

CONTEXTUAL FACTORS

PROCESS FACTORS

- Political Climate

- Resources

- Catalysts

- Leadership

- Communication

- Community Development

- Sustainability

- Understanding Community

- Research & Evaluation

- Policies/Laws/Regulations

- History of Working Together

- Connectedness

CORE FOUNDATION: VISION

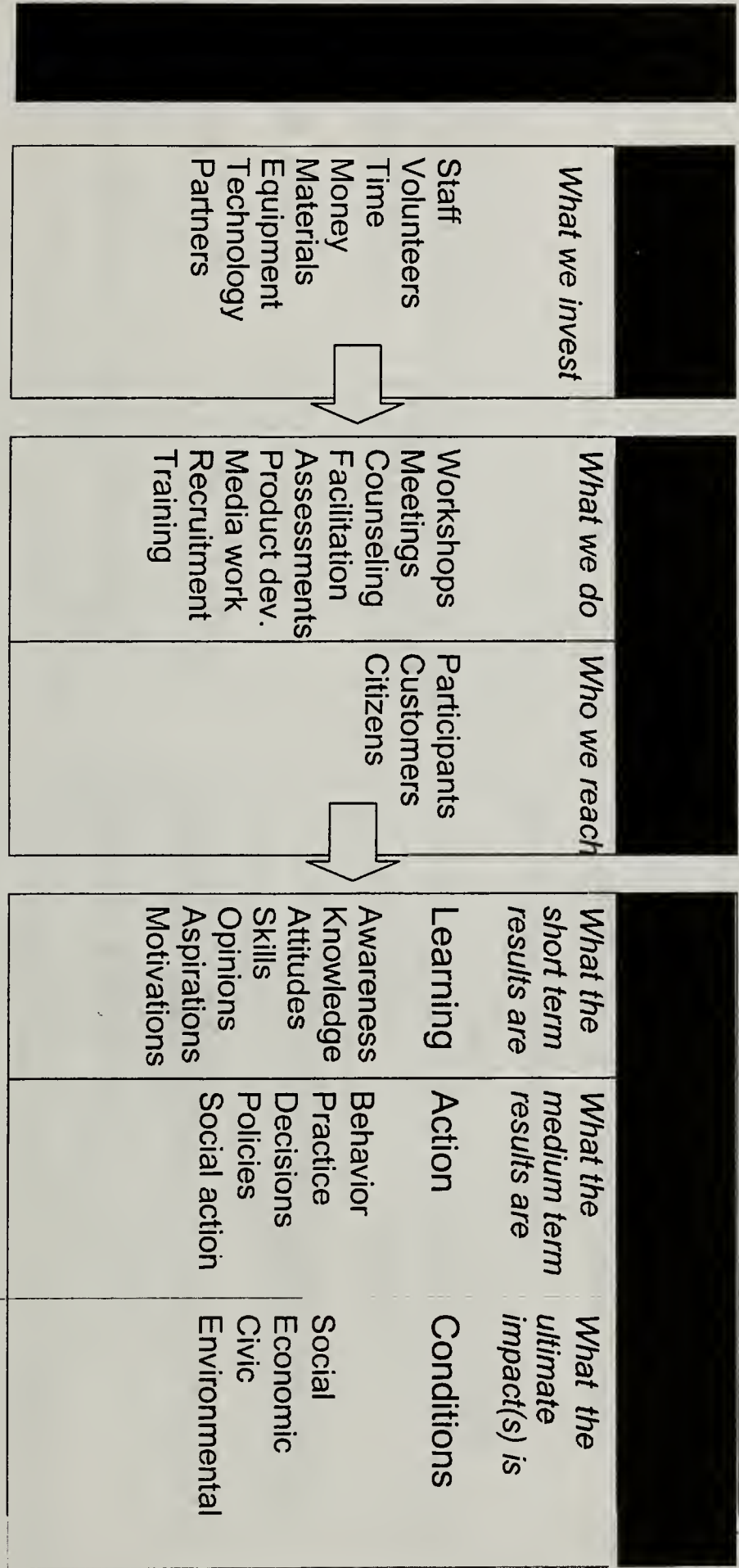
MISSION

VALUES/PRINCIPLES

GROUNDING: DIVERSITY

National Network for Collaboration

LOGIC MODEL: Program Performance Framework



ASSUMPTIONS

- 1)
- 2)
- 3)
- 4)

ENVIRONMENT

Influential factors

Evaluation Worksheet

What do you want to know? Evaluation Questions	How will you know it? Indicators	Sources of Information	Data Collection Methods and Timing

Question to be Answered	Possible Indicator
Are the collaborative's members satisfied with the group's work?	Meeting attendance (number and frequency) Complaints (number and type) Member satisfaction
Has the collaborative helped agencies work together?	Increase in communications among agencies Number of agencies who share resources Clients' perspective
Has the collaborative helped at-risk students perform better in school?	Decrease in truancy Number of students who improve their grades Number of students who increase their participation in extracurricular activities

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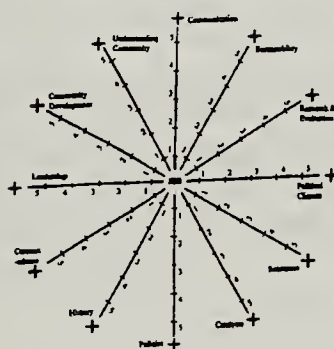
Amherst H. Wilder Foundation 1996

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National Network of Collaborations

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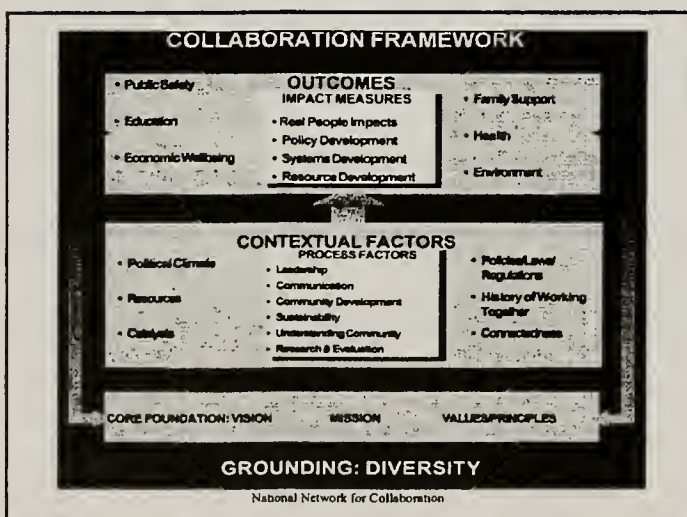
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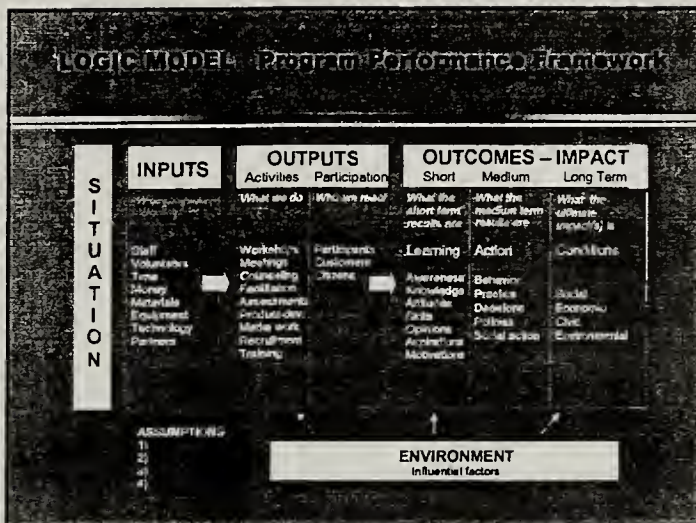
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Best Practices and
Practical Applications

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Workshop 2

Best Practices and Practical Applications

Starting Coalitions

Maintaining Coalitions

Evaluating Coalitions

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Starting Coalitions

- What Works
- Best Practices
- What Doesn't Work

Maintaining Coalitions

- What Works
- Best Practices
- What Doesn't Work

Starting Coalitions: Implications for Collaborations

In a Michigan State University Study on Coalitions for Youth and Families, they found the following necessary for success:

- Diversity
- Open Communication and Trust
- Early Success
- Leadership
- Planning
- Needs Assessment or Community Scan

Maintaining Coalitions: Challenges for Collaborations

In a Michigan State University Study on Coalitions for Youth and Families, they found the top challenges to be:

- Inadequate funding
- Resistance to involvement from a critical community sector
- Lack of involvement of socially disadvantaged
- Turf issues (territorial issues, who should chair, and conflicting personalities of the members)

Maintaining Coalitions

Implications for Collaborations

- Evaluate the Results
- Continually Improve the Work
- Renew the Effort (Retire and Add Members)
- Celebrate

Evaluating Coalitions

Challenges for Collaborations

- Overall documented evidence for collaboration outcomes is weak.
- Collaborations have reported to achieve positive and dramatic outcomes in literature.

Why Are Collaborative Efforts Hard to Evaluate?

- Coalitions are not well defined so its hard to replicate them or consider them representative of other coalitions.
- Many potential variables extraneous to the coalition which can affect the evaluation.
- Researchers consider “control group” essential to good research so they can compare it to the “treatment group.”

Why Are Collaborative Efforts Hard to Evaluate?

- Coalitions often choose varied (not consistent) outcomes to measure their effectiveness, making comparisons across coalitions difficult.
- Coalitions often need years to show long term results (hence the need for immediate term results). Often they don't have strong models that link immediate with long term results.

Why Are Collaborative Efforts Hard to Evaluate?

- Pressures associated with funding and political factors can inadvertently distort a coalition's function – causing havoc with the evaluation.
- Coalitions can be hard to evaluate because of their very real complexity.

Evaluating Coalitions

- What Works
- Best Practices

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Amherst H. Wilder Foundation 1996

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Kentucky PEP 2003

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Kentucky PEP 2003

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Kentucky PEP 2003

Evaluating Coalitions

- What Works
- Best Practices

Rebecca Vargas-Jackson, M.D.

*Cultural Competence in Health Care and Health Education
Curriculum Design - Low Literacy*

Cultural Competence in Health Care & Health Education Curriculum Design - Low Literacy

Rebecca Vargas-Jackson, M.D.

Literacy

Ability to read, write, & speak a language and compute & solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential

Bi-literacy

A reading/writing process that extends to another language

The National Adult Literacy Survey (NALs) conducted in 1992

The National Adult Literacy Survey

(NALS)

Measures

Functional Literacy on 3 Scales

- ☒ Prose Literacy
 - ☒ Document Literacy
 - ☒ Quantitative Literacy
-
- ☒ NALS scores varied from 1 to 5
 - ☒ 1 is the lowest score & 5 is the highest
 - ☒ 47%-51% of adults score at Level 1&2

Needed Literacy Skills

- ✉ The National Governors Association has determined that, adults in the U.S. need NALS level 3 or higher in English to fully function in today's society
- ✉ Between 16% and 29% of adults scoring at NALS Level 1 held a high school diploma
- ✉ Between 33% and 38% of adults scoring at NALS Level 2 held a high school diploma
- ✉ Between 19% and 20% of adults scoring on NALS Levels 1 & 2 are graduates of 4 year colleges

Types of Literacy Skills

- ☒ Prose literacy-skill needed to understand & use information from a text, interpret instructions
- ☒ Document Literacy-skill required to locate & use information in standard forms, bus schedules, job applications, prescriptions, maps, tables, graphs, etc
- ☒ Quantitative literacy-skill required to apply mathematics operations, balancing check books, interest on loans, complete an order form, etc

Health Literacy Definitions

☒ Healthy People 2010 defines Health Literacy as
“The degree to which individuals have the capacity to obtain, process & understand health information & services needed to make appropriate health decisions” in a **particular** language

☒ Functional health literacy in the U.S. is the ability to use English to solve health related problems, at a proficiency level that enables one to function, achieve one’s health goals, and develop health knowledge and potential

Rudd, 2000

Health Literacy-Reading/Writing Only?

- ☒ In these definitions no reference is made to the cultural literacy needed to be a wise health care customer in the U.S.
- ☒ Not knowing the expected roles of patient and health care provider or how to access & navigate the extremely complicated system of care in the U.S., can seriously impede one's quest for health.
- ☒ None of the definitions spell out the crucial importance of language & culture in health care for LEP persons....

Low Literacy

☒ By the end of fourth grade, students should be able to read orally with appropriate expression, locate materials appropriate to a topic, use graphic aids to locate and interpret information and analyze text in a variety of genres. They become literate.

☒ Low Literacy is the limited ability to read, write & speak in any language

Low-Literacy Groups in The U.S.

I. Individuals with English as one's maternal language

II. Individuals with other than English as one's maternal language

- ☒ The ones unable to read and write in their own language and/or English
- ☒ The ones with “advanced” education in their maternal language, but Limited English Proficient

LEP – Low Literacy Individuals

- ☒ Limited English Proficient (LEP) individuals under the Law are all individuals that have a “primary” language **other** than English
- ☒ **ALL** LEP individuals have the right of being offered information/education in their primary language and a free-of-charge interpreter....
- ☒ **ALL** LEP individuals deserve the same access to health information/education system as non-LEPs
- ☒ **ALL** Health Care facilities/systems have the obligation of compliance with The Civil Rights Act of 1964

Low Literacy Individuals-Facts

- ✉ Approximately **40** million people in the U.S. age 16 and older have low literacy skills
- ✉ **40%** of people with low literacy skills live in poverty
- ✉ **17%** of people with low literacy skills receive food stamps, if documented or U.S. citizens
- ✉ **70%** of people with low literacy skills are unemployed or under-employed (manual laborers)

Education/Literacy is Cultural Construct

Culture embraces the thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines

- ☒ **how education/literacy information is received**
- ☒ **how rights and protections are exercised**
- ☒ **what is considered an education minimum standard**
- ☒ **how concerns about literacy are expressed**
- ☒ **who should provide literacy assistance**
- ☒ **what type of assistance should be given &**
- ☒ **who deserves to be educated, become literate.**

Health Literacies in the U.S.

- ☒ Basic Literacy: *comprehension*, skill for understanding of: prescriptions, appointment cards, medicine labels, instructions for care, etc
- ☒ Interactive Literacy: *participation*, skills for decision making on health, independent action, partnership with professionals, etc
- ☒ Critical Literacy: *analysis & action*, skills for analysis, engagement, social action applied to community, work or policy

Culture

- ☒ Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values (example, value of an education versus survival, children working in the fields...to eat...) and institutions of ethnic, religious or social groups.

Curriculum

- ✉ The aggregate of material and topics of a particular course of study in a school, college, educational institution or university

International Perspective

✉ *ILS; International Literacy Surveys*
conducted in 20 industrialized countries
since 1994:

U.S. adults score at an average level of
prose literacy performance when compared
with adults in other industrialized countries.

Prose Literacy Proficiency of Adults

Aged 26-65

Higher than US	Not Different	Lower than US
Finland	New Zealand	Czech Republic
Norway	Australia	Slovenia
Sweden	Canada	Poland
Switzerland	Netherlands	Hungary

To Write for LI Groups, Know Your Target Population

- ☒ To design a Cultural & Linguistic competent curriculum for low literacy individuals, you need to know your target population
- ☒ Their literacy level is only one component from the long list of cultural factors
- ☒ Your target populations change accordingly with:
migration patterns, changes in laws, wars and displacement of populations around the world, generations, birth control, political, & religious issues, etc

Knowing your Environment

Cultural & Linguistic Competency Resource & Needs

Assessment (C&LC/R&NA)

✉ At Institutional Level

- High management level CEO, CFO, Executive Director: Mission, Vision, Policies, Procedures
- Mid-Management: enforcers of compliance
- Professionals: directly responsible for compliance
- Staff and volunteers: the ones complying
- Partners, affiliates: do all share same view?
- Others, pursuant to program needs

Knowing your Target Population

Cultural & Linguistic Competency Resource & Needs

Assessment (C&LC/R&NA)

✉ At Community Level

- Focus Groups
- Key Informant Interviews
- Phone Surveys
- Face-to-face Surveys
- Workshops/Seminars
- Site Visits
- Other, according to your institution/program

Main Topics of the C&LC/R&NA

Cultural Components

- Age, Gender, and Generation
- National Origin, Number of Generations in the U.S.
- Maternal Language, Knowledge of English
- Socio-Economic Status, **Education/Literacy Level**
- Religious Beliefs, Political Beliefs
- Customs, Traditions, Beliefs, & Taboos
- Perception of Health, Well-being, and Disability
- Family & Household Composition,
- Perception of Family & Community
- Other, as per program needs

H/L Perception of Health Definitions

- ☒ In Latin America “Health is the perfect harmony between your internal world and your external world”
- ☒ In the U.S. “Health is the absence of illnesses”
- ☒ Health care is a **right** around the world with the exception of the U.S.
- ☒ 2 decades ago, before Mandela, only South Africa and the U.S. did not hold that health care was a right...

Health Care is Cultural Construct

Culture embraces the thoughts, communication,

actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines

- ☒ **how** health care information is received
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- ☒ **how** symptoms and concerns about the problem are expressed
- ☒ **who** should provide treatment for the problem &
- ☒ **what** type of treatment should be given

Barriers to Access The U.S. Health Care System

- ✉ Linguistic, Low Literacy/Limited English Proficient
- ✉ Cultural, use of flyers and translated propaganda with messages for different target populations instead of radio, TV, and other Latino media for H/L
- ✉ Economic (high cost of education & ESL, lack of child care, risk job loss if attending training programs)
- ✉ Transportation, location of facilities, lack of adequate public transportation system

Barriers cont.

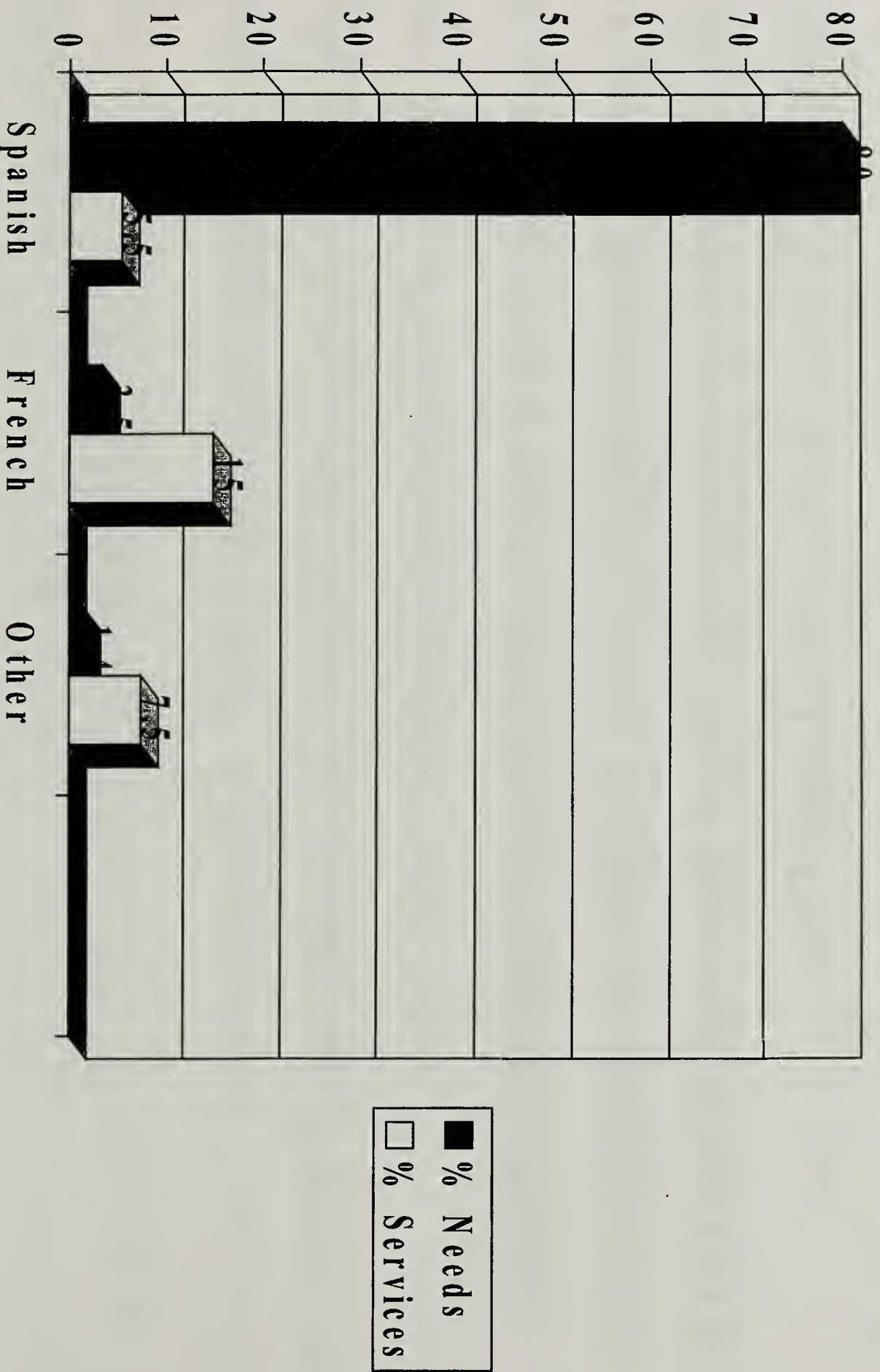
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✉ Other

LEP-Low Literacy Level OB/GYN Patients at Local Hospital



LEP-Low Literacy Level Patients 2001-2003 Local Health Department



Hispanic/Latino Facts

☒ There is a saying, “in 1492, Christopher Columbus landed in “America” the new world, and 9 months later the first Hispanic/Latino was born.”

☒ H/L ancestry is a mix of Mayas, Aztecs, Incas, natives of the northern part of the continent of America and immigrants from the continents of Europe, Africa, Asia, and Oceania.

☒ H/L ancestors were part of what is today called the U.S. when Caucasian ancestors were still living in Europe

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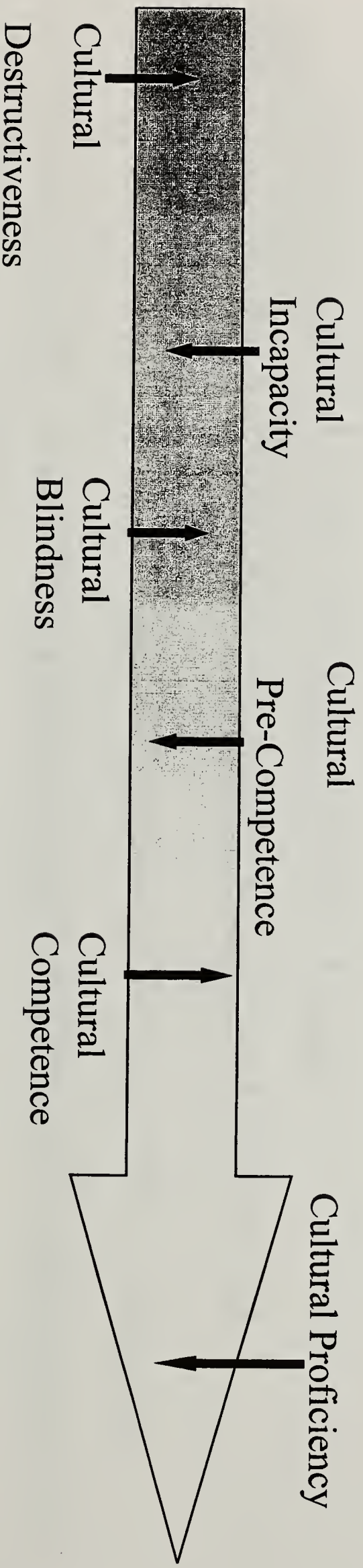
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- ☒ H/Ls represent 17% of the children in the U.S. but they account for 25% of the pediatric AIDS cases
- ☒ One-third of H/Ls, 35.5% lack health insurance coverage
- ☒ Over one-quarter, 30% of H/L children lacked any form of health insurance
- ☒ Diabetes and overweight are endemic in the H/L community

Cultural & Linguistic Competence

☒ Cultural & linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

☒ Implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by patients/consumers and their communities. In summary, IT'S A SKILL

The Cultural Competence Continuum



Cultural Destructiveness



Cultural Destruction

- ☒ Individuals view cultural differences as a problem
- ☒ Individuals purposely attempt to destroy a culture
- ☒ Example: Treatment of Native Americans by immigrants from Europe since 1500...
- ☒ Assumption that one race is superior and should eradicate “lesser” cultures

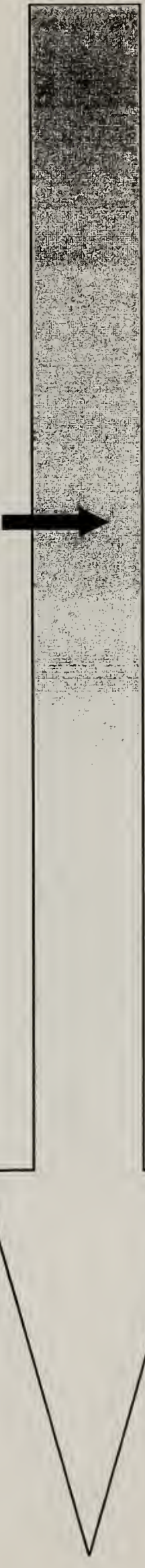
Cultural Incapacity

Cultural
Incapacity



- ☒ Organizations lack capacity to help individuals from diverse cultures
- ☒ Do **not** intentionally seek to cause harm
- ☒ Believe in superiority of their own race
- ☒ Oppress by enforcing racist policies and stereotypes
- ☒ Employment practices are discriminatory

Cultural Blindness



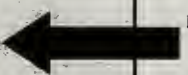
Cultural Blindness

- ☒ Belief that race makes no difference and that “all people are the same” (everything could be in a **high** level English ...)
- ☒ People view themselves as unbiased
- ☒ People do not benefit from valuable differences among cultural groups
- ☒ Services created are useless to address needs of diverse groups

Cultural Pre-Competence

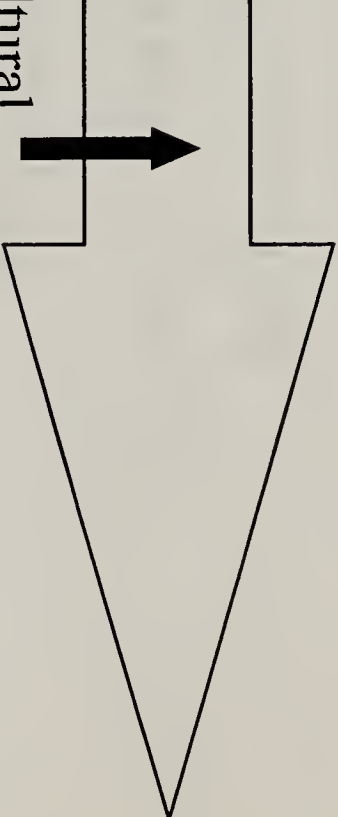
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Pre-Competence



- ☒ Recognition of weakness, lack of training & understanding
- ☒ Efforts to improve services to diverse populations, without Resource & Needs Assessments...
- ☒ Hire **one** staff member from different cultural background to provide **all** services needed...
- ☒ Belief that they have accomplished their goals

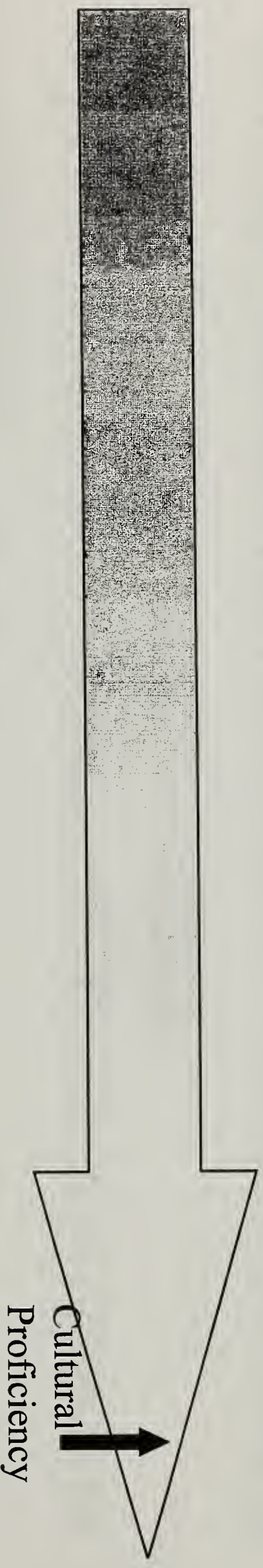
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- ☒ Accept and Respect differences
- ☒ Participate in self-assessment process regarding culture & community Resource & Needs Assessment
- ☒ Continue to expand cultural knowledge, training & education campaigns for staff & community
- ☒ Adapt service models to better serve the needs of **ALL** the community
- ☒ Strive to hire unbiased employees and support staff

Cultural Proficiency



- ☒ Hold **ALL** cultures in high esteem
- ☒ Conduct research to increase knowledge of culturally competent practices
- ☒ New educational and therapeutic approaches
- ☒ Policies, Procedures, Hiring practices, Service delivery, Education campaigns include principles of cultural competency

A Culturally Competent Health Care System/Program is Able to:

- ☒ Respond to current and projected demographic changes
- ☒ Help eliminate long standing health disparities
- ☒ Provide culturally competent patient health related information/education
- ☒ Expand choices and access to high-quality clinicians & services by the public in general
- ☒ Achieve greater patient adherence to medical advice, thereby increasing patient compliance

Low Literacy - Curriculum Design

Once the cultural construct of your target population is identified, which includes their literacy level:

- ☒ Use best practices already in use for your target population
- ☒ Use existing successful models
- ☒ Develop & design curricula with participation of key members of your target population
- ☒ Test curricula before implementation phase
- ☒ Monitor & evaluate results on constant basis
- ☒ Make appropriate changes and adjustments

Reaching Low Literacy Populations

- ☒ Develop cultural & linguistic appropriate Tools & Instruments (video-tapes, audio-tapes, etc)
- ☒ Develop & implement Cultural and Linguistic Competent **A**wareness campaigns
- ☒ Develop & implement Cultural & Linguistic Competent **O**utreach & **E**ducation Interventions
- ☒ Facilitate/improve **a**ccess to your service delivery system from LEP, Low Literacy individuals
- ☒ Develop or improve **p**artnerships/alliances with members, and organizations serving or potentially serving your targeted community

Improving Health Literacy

Armed with the appropriate tools & instruments and having developed culturally competent interventions:

- ③ Facilitate a behavioral change
- ③ Promote cultural understanding
- ③ Utilize social marketing techniques to reach your goals
- ③ Function as broker between health care providers & health care recipients
- ③ Become a link between community & system
- ③ Listen to targeted communities silent suggestions... assessing interventions/results constantly

Quick Tips for Writing Low Literacy Materials

- ☒ Keep writing style simple
- ☒ Use active voice & conversational style
- ☒ Sequence main points in a logical manner
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- ☒ Use short words and sentences
- ☒ Avoid double negative expressions
- ☒ Use same word consistently rather than synonyms
- ☒ For lengthy materials, use a simple table of content

Quick Tips for Writing Low-Literacy...

9. Write short summaries at the end of long sections
10. Use a larger type than 12 points for the text
11. Enlarge or bold type in heading and subheading
12. Use extra white space to separate sections
13. Use age appropriate ILLUSTRATIONS
14. Place illustrations close to related text
15. Use maps, grids, & other VISUALS to ease the reading
16. Write in a **cultural & linguistic** competent manner

Literacy & Health Status-Facts

☒ Low literacy is associated with less understanding, use of mammography

Davis et al, 1996

☒ People with low literacy skills come into care with more advance stages of prostate cancer

Bennett et al, 1998

☒ Illiteracy and poor health status are independently associated

Weiss et al, 1992

☒ Patients with inadequate health literacy were more likely to report their health as poor

Baker et al, 1997

☒ Of 1,000 health-oriented web-sites reviewed only 10 were appropriate for low literacy adults

Lazarus & Mora, 2000

Medical Comprehension

General Population Served in Two Public Hospitals in The U.S.

- ☒ 41% of patients in 2 public hospitals did not comprehend basic instructions
- ☒ 26% of patients did not understand appointment slips
- ☒ 60% of patients did not understand informed consent for procedures
- ☒ None of the above patients were selected based on their literacy level

Vermont Focus Group Participants

- ☒ Almost 40% of participants with low functional literacy admitted feelings of shame
- ☒ 67% had never told their spouses (their low-literacy)
- ☒ 53% had never told their children (their low-literacy)

Not everybody's going to walk in the doctor's office when it's full of people and say, Listen, I'm illiterate, I need help! ...you're on your own. And if you can't fill out the information correctly, they're going to score you on that...

Limited Health Literacy Outcomes

- ☒ Silence & Shame
- ☒ Limited Participation
- ☒ Lost Entitlements
- ☒ Lost Rights
- ☒ Exclusion, Isolation
- ☒ Defeated & Lost
- ☒ Cover up & Lie
- ☒ Compromised Health Care
- ☒ Compromised Health

Health & Education are Linked

Death rates for

- Chronic diseases
- Communicable diseases
- Injuries

Are all inversely related to education for
men and women

Developing Cultural Competence Curriculum Design-Reaching Low Literacy Populations Improving Health Literacy

Rebecca Vargas-Jackson, M.D.

(703) 978-5201

Cultural Competency in Health Care

There are men that battle for one day and they are good

There are others that battle for one year and they are better

There are those that battle for many years and they are very good

But, there are some that battle all their lives ...

Those are the indispensable ones.

Bertolt Brecht (1898-1956)



Cultural Competence in Health Care & Health Education Curriculum Design - Low Literacy

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Literacy

Ability to read, write, & speak a language and compute & solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential

Bi-literacy

A reading/writing process that extends to another language

The National Adult Literacy Survey (NALS) conducted in 1992



The National Adult Literacy Survey (NALS)

Measures

Functional Literacy on 3 Scales

- ✦ Prose Literacy
- ✦ Document Literacy
- ✦ Quantitative Literacy

- ✦ NALS scores varied from 1 to 5
- ✦ 1 is the lowest score & 5 is the highest
- ✦ 47%-51% of adults score at Level 1&2



Needed Literacy Skills

- ♦ The National Governors Association has determined that, adults in the U.S. need NALS level 3 or higher in English to fully function in today's society
- ♦ Between 16% and 29% of adults scoring at NALS Level 1 held a high school diploma
- ♦ Between 33% and 38% of adults scoring at NALS Level 2 held a high school diploma
- ♦ Between 19% and 20% of adults scoring on NALS Levels 1 & 2 are graduates of 4 year colleges



Types of Literacy Skills

- ♦ Prose literacy-skill needed to understand & use information from a text, interpret instructions
- ♦ Document Literacy-skill required to locate & use information in standard forms, bus schedules, job applications, prescriptions, maps, tables, graphs, etc
- ♦ Quantitative literacy-skill required to apply mathematics operations, balancing check books, interest on loans, complete an order form, etc



♦ National Center for Education Statistics, 1993

Health Literacy Definitions

- ♦ Healthy People 2010 defines Health Literacy as "The degree to which individuals have the capacity to obtain, process & understand health information & services needed to make appropriate health decisions" in a **particular** language
- ♦ Functional health literacy in the U.S. is the ability to use English to solve health related problems, at a proficiency level that enables one to function, achieve one's health goals, and develop health knowledge and potential



Rudd, 2000

Health Literacy-Reading/Writing Only?

- ♦ In these definitions no reference is made to the cultural literacy needed to be a wise health care customer in the U.S.
- ♦ Not knowing the expected roles of patient and health care provider or how to access & navigate the extremely complicated system of care in the U.S., can seriously impede one's quest for health.
- ♦ None of the definitions spell out the crucial importance of language & culture in health care for LEP persons....

www.hsph.harvard.edu/healthliteracy



Low Literacy

- ♦ By the end of fourth grade, students should be able to read orally with appropriate expression, locate materials appropriate to a topic, use graphic aids to locate and interpret information and analyze text in a variety of genres. They become literate.
- ♦ Low Literacy is the limited ability to read, write & speak in any language

♦ The Ohio Literacy Initiative



Low-Literacy Groups in The U.S.

I. Individuals with English as one's maternal language

II. Individuals with other than English as one's maternal language

- ♦ The ones unable to read and write in their own language and/or English
- ♦ The ones with "advanced" education in their maternal language, but Limited English Proficient



LEP – Low Literacy Individuals

- ♦ Limited English Proficient (LEP) individuals under the Law are all individuals that have a “primary” language **other** than English
- ♦ **ALL** LEP individuals have the right of being offered information/education in their primary language and a free-of-charge interpreter....
- ♦ **ALL** LEP individuals deserve the same access to health information/education system as non-LEP
- ♦ **ALL** Health Care facilities/systems have the obligation of compliance with The Civil Rights Act of 1964

Low Literacy Individuals-Facts

- ♦ Approximately **40** million people in the U.S. age 16 and older have low literacy skills
- ♦ **40%** of people with low literacy skills live in poverty
- ♦ **17%** of people with low literacy skills receive food stamps, if documented or U.S. citizens
- ♦ **70%** of people with low literacy skills are unemployed or under-employed (manual labor)

♦ U.S. Congress, Office of Technology Assessment, 1993

Education/Literacy is Cultural Construct

Culture embraces the thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines

- ♦ **how** education/literacy information is received
- ♦ **how** rights and protections are exercised
- ♦ **what** is considered an education minimum standard
- ♦ **how** concerns about literacy are expressed
- ♦ **who** should provide literacy assistance
- ♦ **what** type of assistance should be given &
- ♦ **who** deserves to be educated, become literate.

Health Literacies in the U.S.

- ♦ Basic Literacy: *comprehension*, skill for understanding of: prescriptions, appointment cards, medicine labels, instructions for care, etc
- ♦ Interactive Literacy: *participation*, skills for decision making on health, independent action, partnership with professionals, etc
- ♦ Critical Literacy: *analysis & action*, skills for analysis, engagement, social action applied to community, work or policy



Culture

- ♦ Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values (example, value of an education versus survival, children working in the fields...to eat...) and institutions of ethnic, religious or social groups.



Curriculum

- ♦ The aggregate of material and topics of a particular course of study in a school, college, educational institution or university



International Perspective

- ♦ *ILS; International Literacy Surveys* conducted in 20 industrialized countries since 1994:

U.S. adults score at an average level of prose literacy performance when compared with adults in other industrialized countries.

Tuijnman, Benchmarking Adult Literacy in the U.S. September 2007



Prose Literacy Proficiency of Adults Aged 26-65

Higher than US	Not Different	Lower than US
Finland	New Zealand	Czech Republic
Norway	Australia	Slovenia
Sweden	Canada	Poland
Switzerland	Netherlands	Hungary



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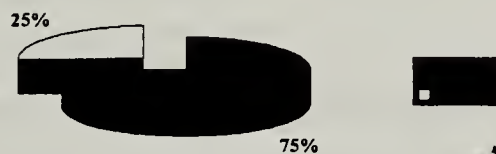
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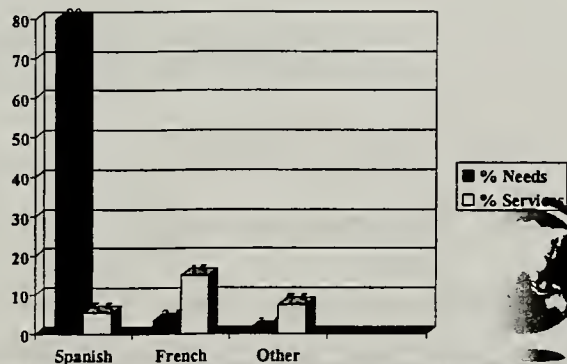
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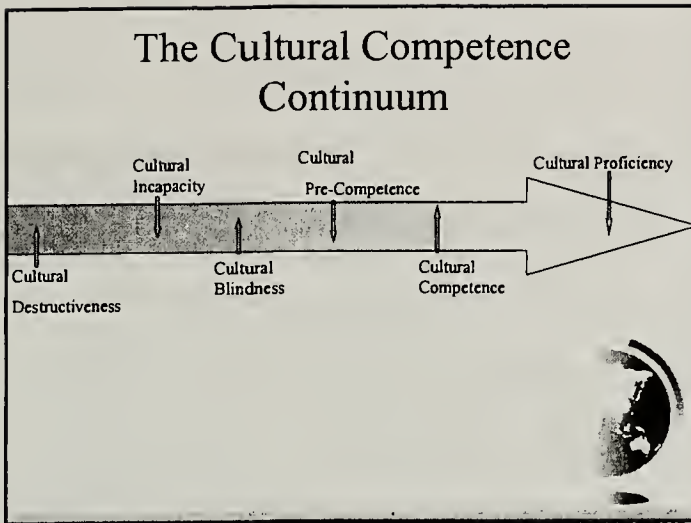
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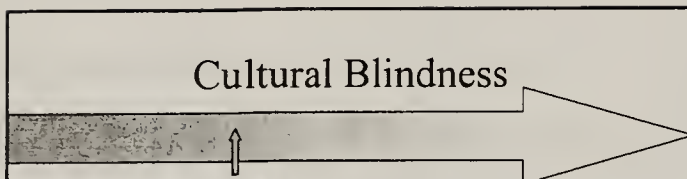
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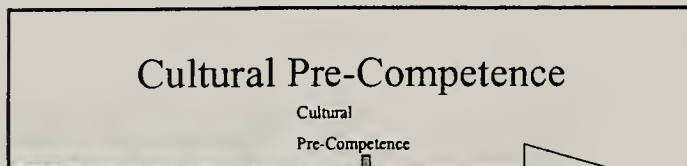


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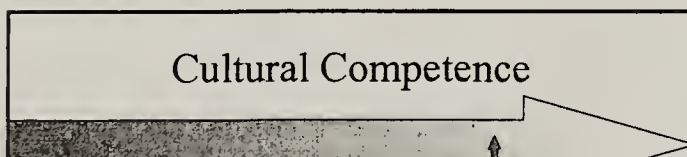


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- ♦ For lengthy materials, use a simple table of content

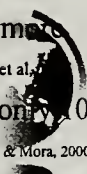
Quick Tips for Writing Low-Literacy...

9. Write short summaries at the end of long sections
10. Use a larger type than 12 points for the text
11. Enlarge or bold type in heading and subheading
12. Use extra white space to separate sections
13. Use age appropriate ILLUSTRATIONS
14. Place illustrations close to related text
15. Use maps, grids, & other VISUALS to ease the reading
16. Write in a **cultural & linguistic** competent manner



Literacy & Health Status-Facts

- ♦ Low literacy is associated with less understanding, use of mammography Davis et al, 1996
- ♦ People with low literacy skills come into care with more advance stages of prostate cancer Bennett et al, 1998
- ♦ Illiteracy and poor health status are independently associated Weiss et al, 1992
- ♦ Patients with inadequate health literacy were more likely to report their health as poor Baker et al, 1997
- ♦ Of 1,000 health-oriented web-sites reviewed only 10 were appropriate for low literacy adults Lazarus & Mora, 2000



Medical Comprehension

General Population Served in Two Public Hospitals
in The U.S.

- ♦ 41% of patients in 2 public hospitals did not comprehend basic instructions
- ♦ 26% of patients did not understand appointment slips
- ♦ 60% of patients did not understand informed consent for procedures
- ♦ None of the above patients were selected based on their literacy level



Williams et al, 1998

Vermont Focus Group Participants

- ♦ Almost 40% of participants with low functional literacy admitted feelings of shame
- ♦ 67% had never told their spouses (their low-literacy)
- ♦ 53% had never told their children (their low-literacy)

Not everybody's going to walk in the doctor's office when it's full of people and say, Listen, I'm illiterate, I need help! ...you're on your own. And if you can't fill out the information correctly, they're going to score you on that...

Limited Health Literacy Outcomes

- ♦ Silence & Shame
- ♦ Limited Participation
- ♦ Lost Entitlements
- ♦ Lost Rights
- ♦ Exclusion, Isolation
- ♦ Defeated & Lost
- ♦ Cover up & Lie
- ♦ Compromised Health Care
- ♦ Compromised Health

Health & Education are Linked

Death rates for

- Chronic diseases
- Communicable diseases
- Injuries

Are all inversely related to education for men and women

Pamuk et al, Health Affairs, 199

Developing Cultural Competence
Curriculum Design-Reaching Low
Literacy Populations
Improving Health Literacy

Rebecca Vargas-Jackson, M.D.
(703) 978-5201



Cultural Competency in Health Care

There are men that battle for one day and they are
good
There are others that battle for one year and they are
better
There are those that battle for many years and they
are very good
But, there are some that battle all their lives ...
Those are the indispensable ones.

Bertolt Brecht (1898-1956)



Curriculum Design Contents

- 1 **Heart-Healthy Home Cooking African American Style**
<http://www.nhlbi.nih.gov/health/public/heart/other/chdblack/cooking.htm>
From the National Heart, Lung and Blood Institute (<http://www.nhlbi.nih.gov>)

- 2 **Steps to Manage Your Diabetes in Various Asian and Pacific Islander Languages:**
Chinese—<http://www.aapcho.org/download/StMYD-Chinese.pdf>
Korean—<http://www.aapcho.org/download/StMYD-Korean.pdf>
Samoan—<http://www.aapcho.org/download/StMYD-Samoan.pdf>
Tagalog—<http://www.aapcho.org/download/StMYD-Tagalog.pdf>
Vietnamese—<http://www.aapcho.org/download/StMYD-Vietnamese.pdf>
From the Association of Asian Pacific Health Organizations (<http://www.aapcho.org/>)

- 3 **Family Literacy El Civics Health Curriculum**
<http://www.aelweb.vcu.edu/publications/famlitcurric/pdf/health.pdf>
From the Family Literacy Curriculum of Fairfax County (<http://www.aelweb.vcu.edu/publications/famlitcurric/>)

- 4 **Heal: BCC Curriculum**
Health Education and Adult Literacy: Breast & Cervical Cancer
<http://www.worlded.org/us/health/heal/healBccHtml/index.htm>
From World Education (<http://www.worlded.org/>)

- 5 **Making Health Communication Programs Work**
<http://www.nci.nih.gov/pinkbook>
From the National Cancer Institute (<http://www.nci.nih.gov>)

- 6 **African American Curriculum**

- 7 **Asian American Curriculum**

- 8 **Hispanic Curriculum**

- 9 **Multicultural Curriculum**

Heart-Healthy Home Cooking *African American Style*



NATIONAL INSTITUTES OF HEALTH
NATIONAL HEART, LUNG, AND BLOOD INSTITUTE
AND OFFICE OF RESEARCH ON MINORITY HEALTH





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INTRODUCTION

Good food is one of life's great joys. And good meals are a shared pleasure at the heart of African American family life and special celebrations. This recipe book brings together many African American favorite recipes, prepared in a heart-healthy way lower in fat, especially saturated fat, cholesterol, and sodium!

It shows how to prepare dishes in ways that help protect you and your family from heart disease and stroke. This is important because heart disease is the first and stroke is the third leading cause of death for African Americans. So, by making small changes in the way you and your family eat, you can help reduce your risk for heart disease and stroke.

So make a start today. Give those old favorites a new, tasty, heart-healthy makeover. And help keep the heart of your family strong!

The cookbook was developed by the National Heart, Lung, and Blood Institute and the Office of Research on Minority Health, both part of the National Institutes of Health in Bethesda, Maryland.

Abbreviations used throughout this book include:

tsp = teaspoon

Tbsp = tablespoon

oz = ounce

lb = pound

g = gram

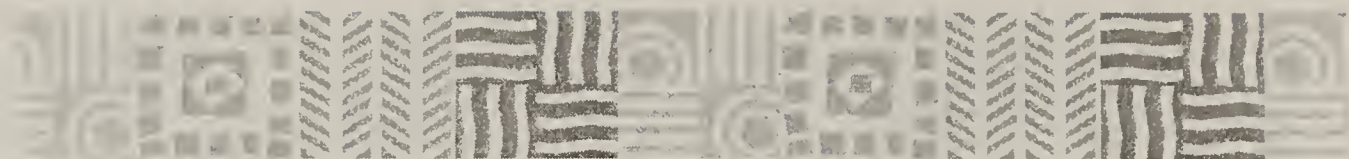
mg = milligram





Breads, Vegetables, and Side Dishes





Breads, Vegetables, and Side Dishes

GOOD-FOR-YOU CORNBREAD

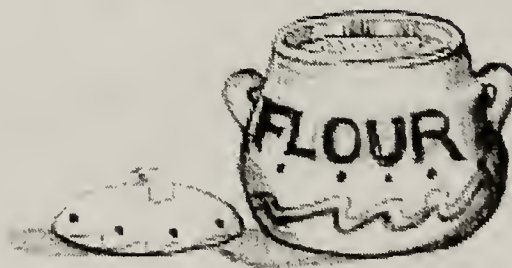
1 cup	cornmeal
1 cup	flour
1/4 cup	white sugar
1 tsp	baking powder
1 cup	buttermilk, 1% fat
1	egg, whole
1/4 cup	margarine, regular, tub
1 tsp	vegetable oil (to grease baking pan)

Use 1% milk and a small amount of margarine to make this cornbread lower in saturated fat and cholesterol.

1. Preheat oven to 350° F.
2. Mix together cornmeal, flour, sugar, and baking powder.
3. In another bowl, combine buttermilk and egg. Beat lightly.
4. Slowly add buttermilk and egg mixture to the dry ingredients.
5. Add margarine and mix by hand or with a mixer for 1 minute.
6. Bake for 20 to 25 minutes in an 8 by 8-inch greased baking dish. Cool. Cut into 10 squares.



Makes 10 servings
Serving Size: 1 square
Calories 178
Fat 6 g
Saturated fat 1 g
Cholesterol 22 mg
Sodium 94 mg



Breads, Vegetables, and Side Dishes

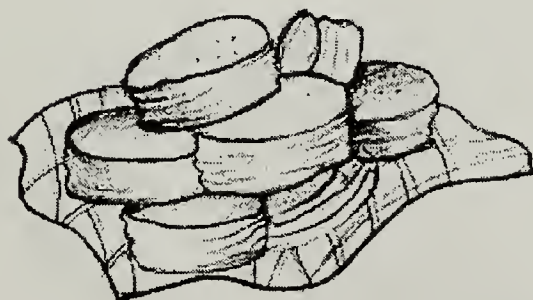
HOMESTYLE BISCUITS

2 cups	flour
2 tsps	baking powder
1/4 tsp	baking soda
1/4 tsp	salt
2 Tbsps	sugar
2/3 cup	buttermilk, 1% fat
3 Tbsps + 1 tsp	vegetable oil



*It's easy to make
homestyle biscuits with
less fat.*

1. Preheat oven to 450° F.
2. In a medium bowl, combine flour, baking powder, baking soda, salt, and sugar.
3. In a small bowl, stir together buttermilk and oil. Pour over flour mixture; stir until well mixed.
4. On a lightly floured surface, knead dough gently for 10 to 12 strokes. Roll or pat dough to 3/4-inch thickness. Cut with a 2-inch biscuit or cookie cutter, dipping cutter in flour between cuts. Transfer biscuits to an ungreased baking sheet.
5. Bake for 12 minutes or until golden brown. Serve warm.



Makes 15 servings

Serving Size: 1 (2-inch) biscuit

Calories	99
Fat	3 g
Saturated fat	less than 1 g
Cholesterol	less than 1 mg
Sodium	72 mg



Breads, Vegetables, and Side Dishes

DELICIOUS OVEN FRENCH FRIES

4	large potatoes (2 lbs)
8 cups	ice water
1 tsp	garlic powder
1 tsp	onion powder
1/4 tsp	salt
1 tsp	white pepper
1/4 tsp	allspice
1 tsp	hot pepper flakes
1 Tbsp	vegetable oil

Oven baking makes these french fries lower in fat and still crispy.

1. Scrub potatoes and cut into long 1/2-inch strips.
2. Place potato strips into ice water, cover, and chill for 1 hour or longer.
3. Remove potatoes and dry strips thoroughly.
4. Place garlic powder, onion powder, salt, white pepper, allspice, and pepper flakes in a plastic bag.
5. Toss potatoes in spice mixture.
6. Brush potatoes with oil.
7. Place potatoes in nonstick shallow baking pan.
8. Cover with aluminum foil and place in 475° F oven for 15 minutes. Remove foil and continue baking uncovered for an additional 15 to 20 minutes or until golden brown. Turn fries occasionally to brown on all sides.

Makes 5 servings

Serving size: 1 cup

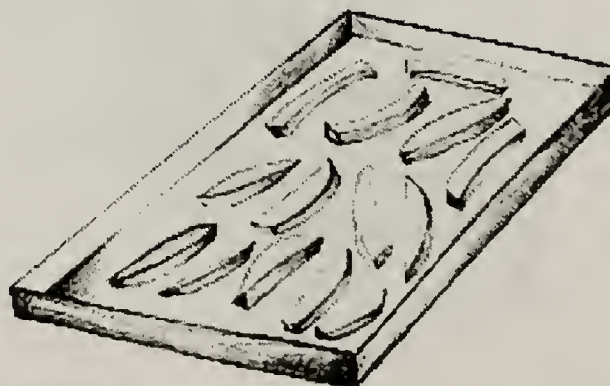
Calories 238

Fat 4 g

Saturated fat 1 g

Cholesterol 0 mg

Sodium 163 mg





Breads, Vegetables, and Side Dishes

SAVORY POTATO SALAD

6 medium	potatoes (about 2 lbs)
2 stalks	celery, finely chopped
2 stalks	scallion, finely chopped
1/4 cup	red bell pepper, coarsely chopped
1/4 cup	green bell pepper, coarsely chopped
1 Tbsp	onion, finely chopped
1	egg, hard boiled, chopped
6 Tbsps	mayonnaise, light
1 tsp	mustard
1/2 tsp	salt
1/4 tsp	black pepper
1/4 tsp	dill weed, dried

Add fresh vegetables and herbs to give a tasty flavor to this potato salad.



1. Wash potatoes, cut in half, and place them in cold water in a saucepan.
2. Cook covered over medium heat for 25 to 30 minutes or until tender.
3. Drain and dice potatoes when cool.
4. Add vegetables and egg to potatoes and toss.
5. Blend together mayonnaise, mustard, salt, pepper, and dill weed.
6. Pour dressing over potato mixture and stir gently to coat evenly.
7. Chill for at least 1 hour before serving.



Makes 10 servings

Serving size: 1/2 cup

Calories	98
Fat	2 g
Saturated fat	less than 1 g
Cholesterol	21 mg
Sodium	212 mg



Breads, Vegetables, and Side Dishes

CANDIED YAMS

3 medium	yams (1 1/2 cups)
1/4 cup	brown sugar, packed
1 tsp	flour, sifted
1/4 tsp	salt
1/4 tsp	ground cinnamon
1/4 tsp	ground nutmeg
1/4 tsp	orange peel
1 tsp	soft tub margarine
1/2 cup	orange juice

*A small amount of
margarine and orange
juice give these yams lots
of flavor but little fat.*

1. Cut yams in half and boil until tender but firm (about 20 minutes). When cool enough to handle, peel and slice into 1/4-inch thickness.
2. Combine sugar, flour, salt, cinnamon, nutmeg, and grated orange peel.
3. Place half of the sliced yams in a medium-sized casserole dish. Sprinkle with spiced sugar mixture.
4. Dot with half the amount of margarine.
5. Add a second layer of yams, using the rest of the ingredients in the same order as above. Add orange juice.
6. Bake uncovered in oven preheated to 350° F for 20 minutes.

Makes 6 servings

Serving size: 1/4 cup

Calories 110

Fat less than 1 g

Saturated fat less than 1 g

Cholesterol 0 mg

Sodium 115 mg





Breads, Vegetables, and Side Dishes

SMOTHERED GREENS

3 cups	water
1/4 lb	smoked turkey breast, skinless
1 Tbsp	hot pepper, freshly chopped
1/4 tsp	cayenne pepper
1/4 tsp	cloves, ground
2 cloves	garlic, crushed
1/2 tsp	thyme
1 stalk	scallion, chopped
1 tsp	ginger, ground
1/4 cup	onion, chopped
2 lbs	greens (mustard, turnip, collard, kale, or mixture)

Use a small amount of skinless smoked turkey breast instead of fatback to lower the fat content but keep the taste.

1. Place all ingredients except greens into large saucepan and bring to a boil.
2. Prepare greens by washing thoroughly and removing stems.
3. Tear or slice leaves into bite-size pieces.
4. Add greens to turkey stock. Cook 20 to 30 minutes until tender.



Makes 5 servings

Serving size: 1 cup

Calories 80

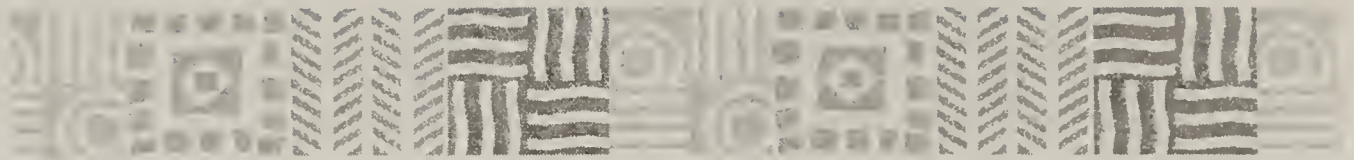
Fat 2 g

Saturated fat less than 1 g

Cholesterol 16 mg

Sodium 378 mg





Breads, Vegetables, and Side Dishes

LIMAS AND SPINACH

2 cups	frozen lima beans
1 Tbsp	vegetable oil
1 cup	fennel, cut in strips (4 oz)
1/2 cup	onion, chopped
1/4 cup	low-sodium chicken broth
4 cups	leaf spinach, washed thoroughly
1 Tbsp	distilled vinegar
1/8 tsp	black pepper
1 Tbsp	raw chives

*Your family will love to eat
more vegetables cooked
this way.*

1. Steam or boil lima beans in unsalted water approximately 10 minutes. Drain.
2. In a skillet, sauté onions and fennel in oil.
3. Add the beans and stock to the onions, cover, and cook for 2 minutes.
4. Stir in the spinach. Cover and cook until spinach has wilted, about 2 minutes.
5. Stir in the vinegar and pepper. Cover and let stand for 30 seconds.
6. Sprinkle with chives and serve.

Makes 7 servings

Serving size: 1/2 cup

Calories 93

Fat 2 g

Saturated fat less than 1 g

Cholesterol 0 mg

Sodium 84 mg



Breads, Vegetables, and Side Dishes

VEGETABLE STEW

3 cups	water
1 cube	vegetable bouillon, low sodium
2 cups	white potatoes, cut in 2-inch strips
2 cups	carrots, sliced
4 cups	summer squash, cut in 1-inch squares
1 cup	summer squash, cut in 4 chunks
1 15-oz can	sweet corn, rinsed and drained (or 2 ears fresh corn, 1 1/2 cups)
1 tsp	thyme
2 cloves	garlic, minced
1 stalk	scallion, chopped
1/2 small	hot pepper, chopped
1 cup	onion, coarsely chopped
1 cup	tomatoes, diced

*This stew is a great way to
use summer vegetables in
a new way.*



(Add other favorite vegetables such as broccoli, cauliflower, etc.)

1. Heat water and bouillon in a large pot and bring to a boil.
2. Add potatoes and carrots to the broth and simmer for 5 minutes.
3. Add the remaining ingredients except for the tomatoes and continue cooking for 15 minutes over medium heat.
4. Remove 4 chunks of squash and purée in blender.
5. Return puréed mixture to pot and let cook for 10 minutes more.
6. Add tomatoes and cook for another 5 minutes.
7. Remove from flame and let sit for 10 minutes to allow stew to thicken.



Makes 8 servings

Serving size: 1 1/4 cups

Calories 119

Fat 1 g

Saturated fat less than 1 g

Cholesterol 0 mg

Sodium 196 mg

Breads, Vegetables, and Side Dishes

CLASSIC MACARONI AND CHEESE

2 cups macaroni
1/2 cup chopped onions
1/2 cup evaporated skim milk
1 medium egg, beaten
1/4 tsp black pepper
1 1/4 cups sharp cheddar cheese (4 oz),
finely shredded, low fat
nonstick cooking oil spray

*Low fat cheese and skim
milk help to make this
favorite dish heart-healthy.*

1. Cook macaroni according to directions. (Do not add salt to the cooking water.) Drain and set aside.
2. Spray a casserole dish with nonstick cooking oil spray.
3. Preheat oven to 350° F.
4. Lightly spray saucepan with nonstick cooking oil spray.
5. Add onions to saucepan and sauté for about 3 minutes.
6. In another bowl, combine macaroni, onions, and the remaining ingredients and mix thoroughly.
7. Transfer mixture into casserole dish.
8. Bake for 25 minutes or until bubbly. Let stand for 10 minutes before serving.

Makes 8 servings

Serving size: 1/2 cup

Calories 200
Fat 4 g
Saturated fat 2 g
Cholesterol 34 mg
Sodium 120 mg



Main Dishes



Main Dishes

JAMAICAN JERK CHICKEN

1/2 tsp	cinnamon, ground
1 1/2 tsp	allspice, ground
1 1/2 tsp	black pepper, ground
1 Tbsp	hot pepper, chopped
1 tsp	hot pepper, crushed, dried
2 tsp	oregano, crushed
2 tsp	thyme, crushed
1/2 tsp	salt
6 cloves	garlic, finely chopped
1 cup	onion, puréed or finely chopped
1/4 cup	vinegar
3 Tbsp	brown sugar
8 pieces	chicken, skinless (4 breasts, 4 drumsticks)

The spices and peppers in this recipe give the chicken a whole new taste.

1. Preheat oven to 350° F.
2. Combine all ingredients except chicken in large bowl. Rub seasoning over chicken.
3. Marinate in the refrigerator for 6 or more hours.
4. Evenly space chicken on nonstick or lightly greased baking pan.
5. Cover with aluminum foil and bake 40 minutes. Remove foil and continue baking for an additional 30 to 40 minutes or until the meat can be easily pulled away from the bone with a fork. The drumsticks may require less cooking time than the breasts.

Makes 6 servings

Serving size: 1/2 breast or 2 small drumsticks

Calories	199
Fat	4 g
Saturated fat	1 g
Cholesterol	81 mg
Sodium	267 mg



Main Dishes

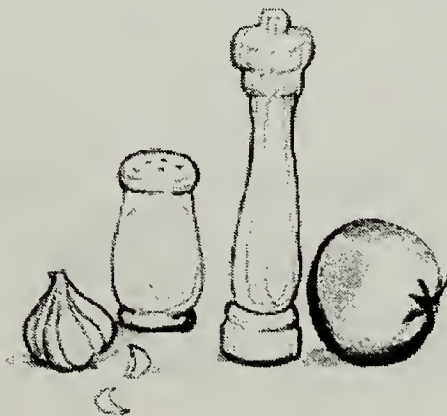
FINGER-LICKING CURRIED CHICKEN

1 1/2 tsp	curry powder
1 tsp	thyme, crushed
1 stalk	scallion, chopped
1 Tbsp	hot pepper, chopped
1 tsp	black pepper, ground
8 cloves	garlic, crushed
1 Tbsp	ginger, grated
3/4 tsp	salt
8 pieces	chicken, skinless (breast, drumstick)
1 Tbsp	olive oil
1 cup	water
1 medium	white potato, diced
1 large	onion, chopped

*Take the skin off chicken
to lower the amount of
saturated fat.*



1. Mix together curry powder, thyme, scallion, hot pepper, cayenne pepper, black pepper, garlic, ginger, onion, and salt.
2. Sprinkle seasoning mixture on chicken.
3. Marinate for at least 2 hours in the refrigerator.
4. Heat oil in skillet over medium flame.
5. Add chicken and sauté.
6. Add water and allow chicken to cook over medium flame for 30 minutes.
7. Add diced potatoes and cook for an additional 30 minutes.
8. Add onions and cook 15 minutes more or until meat is tender.



Makes 6 servings

Serving size: 1/2 breast or 2 small drumsticks

Calories	213
Fat	6 g
Saturated fat	2 g
Cholesterol	81 mg
Sodium	363 mg

Main Dishes

CRISPY OVEN-FRIED CHICKEN

1/2 cup	skim milk or buttermilk
1 tsp	poultry seasoning
1 cup	cornflakes, crumbled
1 1/2 Tbsps	onion powder
1 1/2 Tbsps	garlic powder
2 tsps	black pepper
2 tsps	dried hot pepper, crushed
1 tsp	ginger, ground
8 pieces	chicken, skinless (4 breasts, 4 drumsticks)
a few shakes	paprika
1 tsp	vegetable oil (use to grease baking pan)

*For less fat, bake chicken
in the oven instead of
frying.*

1. Preheat oven to 350° F.
2. Add 1/2 teaspoon of poultry seasoning to milk.
3. Combine all other spices with cornflake crumbs and place in a plastic bag.
4. Wash chicken and pat dry. Dip chicken into milk, shake to remove excess, then quickly shake in bag with seasoning and crumbs.
5. Refrigerate for 1 hour.
6. Remove from refrigerator and sprinkle lightly with paprika for color.
7. Evenly space chicken on greased baking pan.
8. Cover with aluminum foil and bake 40 minutes. Remove foil and continue baking for an additional 30 to 40 minutes or until the meat can be easily pulled away from the bone with a fork. The drumsticks may require less baking time than the breasts. Crumbs will form a crispy "skin." (Do not turn chicken during baking.)

Makes 6 servings

Serving size: 1/2 breast or 2 small drumsticks

Calories	256
Fat	5 g
Saturated fat	1 g
Cholesterol	82 mg
Sodium	286 mg

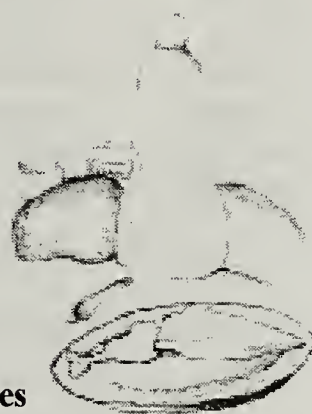


Main Dishes

CHICKEN GUMBO

1 tsp	vegetable oil
1/4 cup	flour
3 cups	low-sodium chicken broth
1 1/2 lbs	chicken breast, skinless and boneless, cut into 1-inch strips
1 cup	white potatoes (1/2 lb), cubed
1 cup	onions, chopped
1 cup	carrots (1/2 lb), coarsely chopped
1/4 cup	celery, chopped
1/2 medium	carrot, grated
4 cloves	garlic, finely minced
2 stalks	scallion, chopped
1 whole	bay leaf
1/2 tsp	thyme
1/2 tsp	black pepper, ground
2 tsps	hot (or jalapeño) pepper
1 cup	okra (1/2 lb), sliced into 1/2-inch pieces

This easy-to-make main dish helps to increase the amount of vegetables you eat and can be made all in one pot.



1. Add oil to a large pot.
2. Heat pot over medium flame.
3. Stir in flour.
4. Cook, stirring constantly, until flour begins to turn golden brown.
5. Slowly stir in all the broth using a wire whisk and cook for 2 minutes. The mixture should not be lumpy.
6. Add all ingredients except okra. Bring to a boil, then reduce heat and let simmer for 20 to 30 minutes.
7. Add okra and let cook for 15 to 20 more minutes.
8. Remove bay leaf.
9. Serve hot in a bowl or over rice.



Makes 8 servings

Serving size: 3/4 cup

Calories 165

Fat 4 g

Saturated fat 1 g

Cholesterol 51 mg

Sodium 81 mg

Main Dishes

SPICY SOUTHERN BARBECUED CHICKEN

5 Tbsps	tomato paste (3 ozs)
1 tsp	ketchup
2 tsps	honey
1 tsp	molasses
1 tsp	Worcestershire sauce
4 tsps	vinegar, white
3/4 tsp	cayenne pepper
1/8 tsp	black pepper
1/4 tsp	onion powder
2 cloves	garlic, minced
1/8 tsp	ginger, grated
1 1/2 lbs	chicken, skinless (breasts, drumsticks)

*Make barbeque sauce
lower in sodium with lots
of herbs and spices.*

1. Combine all ingredients except chicken in a saucepan.
2. Simmer for 15 minutes.
3. Wash chicken and pat dry.
4. Place chicken on a large platter.
5. Brush chicken with 1/2 of sauce mixture.
6. Cover with plastic wrap and marinate in refrigerator for 1 hour.
7. Place chicken on a baking sheet lined with aluminum foil and broil for 10 minutes on each side to seal in juices.
8. Turn oven down to 350° F, and add the remaining sauce to the chicken.
9. Cover the chicken with aluminum foil and continue baking for 30 minutes.



Makes 6 servings

Serving size: 1/2 breast or 2 small drumsticks

Calories	176
Fat	4 g
Saturated fat	less than 1 g
Cholesterol	81 mg
Sodium	199 mg



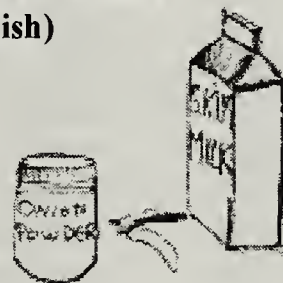
Main Dishes

MOUTh-WATERING OVEN-FRIED FISH

2 lbs	fish fillets
1 Tbsp	lemon juice, fresh
1/4 cup	skim milk or 1% buttermilk
2 drops	hot pepper sauce
1 tsp	garlic, fresh, minced
1/4 tsp	white pepper, ground
1/4 tsp	salt
1/4 tsp	onion powder
1/2 cup	cornflakes, crumbled or regular bread crumbs
1 Tbsp	vegetable oil (for greasing baking dish)
1	lemon, fresh, cut in wedges

For variety, try this heart-healthy fish recipe with any kind of fish.

1. Preheat oven to 475° F.
2. Wipe fillets with lemon juice and pat dry.
3. Combine milk, hot pepper sauce, and garlic.
4. Combine pepper, salt, and onion powder with cornflake crumbs and place on a plate.
5. Let fillets sit in milk briefly. Remove and coat fillets on both sides with seasoned crumbs. Let stand briefly until coating sticks to each side of fish.
6. Arrange on lightly oiled shallow baking dish.
7. Bake 20 minutes on middle rack without turning.
8. Cut into 6 pieces. Serve with fresh lemon.



Makes 6 servings

Serving size: 1 cut piece

Calories	183
Fat	2 g
Saturated fat	less than 1 g
Cholesterol	80 mg
Sodium	325 mg



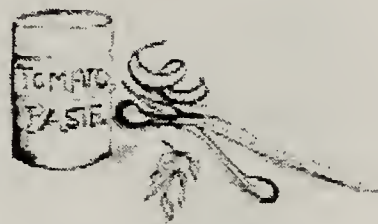
Main Dishes

SCRUMPTIOUS MEAT LOAF

1 lb	ground beef, extra lean
1/2 cup	tomato paste (4 ozs)
1/4 cup	onion, chopped
1/4 cup	green peppers
1/4 cup	red peppers
1 cup	tomatoes, fresh, blanched, chopped
1/2 tsp	mustard, low sodium
1/4 tsp	ground black pepper
1/2 tsp	hot pepper, chopped
2 cloves	garlic, chopped
2 stalks	scallion, chopped
1/2 tsp	ginger, ground
1/8 tsp	nutmeg, ground
1 tsp	orange rind, grated
1/2 tsp	thyme, crushed
1/4 cup	bread crumbs, finely grated



Use extra lean ground beef
to lower the fat content in
this meat loaf.



1. Mix all ingredients together.
2. Place in 1-pound loaf pan (preferably a pan with a drip rack) and bake covered at 350° F for 50 minutes.
3. Uncover pan and continue baking for 12 minutes.

Makes 6 servings

Serving size: 6 (1-1/4-inch) thick slices

Calories	193
Fat	9 g
Saturated fat	3 g
Cholesterol	45 mg
Sodium	91 mg



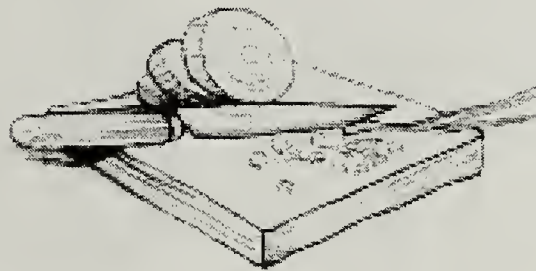
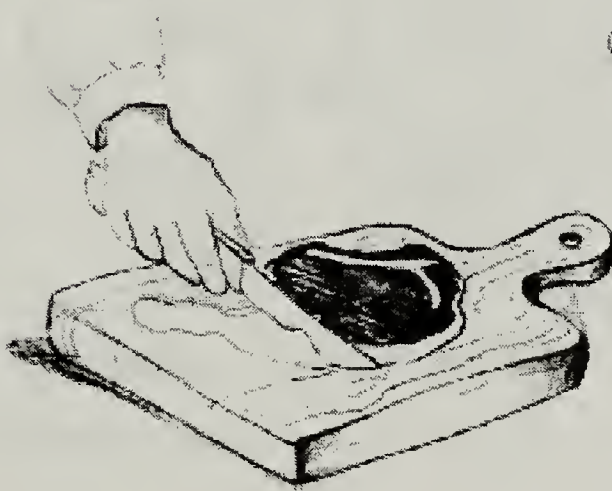
Main Dishes

BAKED PORK CHOPS

6	lean center-cut pork chops, 1/2-inch thick
1 medium	onion, thinly sliced
1/2 cup	green pepper
1/2 cup	red pepper
1/8 tsp	black pepper
1/4 tsp	salt

*Lean cuts of fresh pork
can be included in your
family's heart-healthy
meals.*

1. Preheat oven to 375° F.
2. Trim fat from pork chops. Place chops in a 13 by 9-inch baking pan.
3. Spread onion and peppers on top of chops. Sprinkle with pepper and salt. Refrigerate for 1 hour.
4. Cover pan and bake 30 minutes. Uncover, turn chops, and continue baking for an additional 15 minutes or until no pink remains. Garnish with fresh parsley.



Makes 6 servings

Serving size: 1 chop

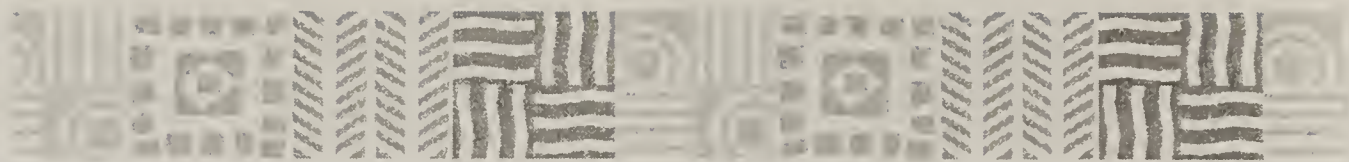
Calories 170

Fat 8 g

Saturated fat 3 g

Cholesterol 61 mg

Sodium 135 mg



Beverage and Desserts



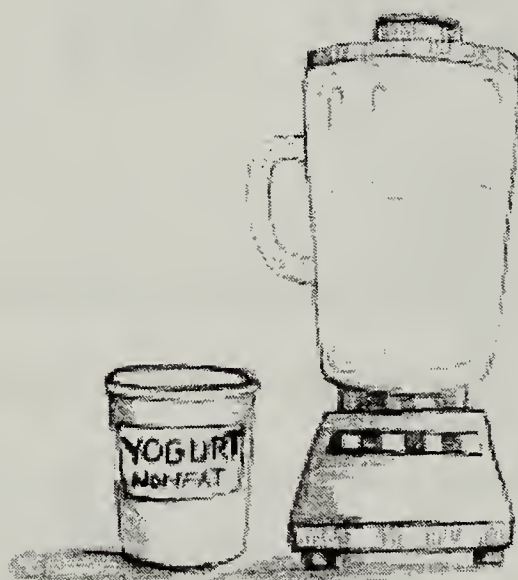
Beverage and Desserts

SUMMER BREEZES SMOOTHIE

1 cup	yogurt, plain nonfat
6 medium	strawberries
1 cup	pineapple, crushed, canned in juice
1 medium	banana
1 tsp	vanilla extract
4	ice cubes

*A perfect low fat thirst
quencher.*

1. Place all ingredients in a blender and purée until smooth.
2. Serve in a frosted glass.



Makes 3 servings

Serving size: 1 cup

Calories	121
Fat	less than 1 g
Saturated fat	less than 1 g
Cholesterol	1 mg
Sodium	64 mg



Beverage and Desserts

MOCK-SOUTHERN SWEET POTATO PIE

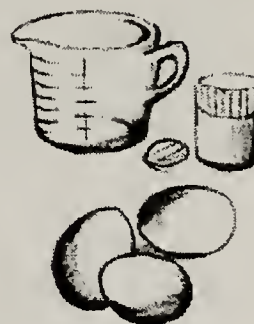
Crust:

1 1/4 cups	flour
1/4 tsp	sugar
1/3 cup	skim milk
2 Tbsps	vegetable oil

*This heart-healthy pie
crust is made with
vegetable oil and skim
milk.*

Filling:

1/4 cup	white sugar
1/4 cup	brown sugar
1/2 tsp	salt
1/4 tsp	nutmeg
3 large	eggs, beaten
1/4 cup	evaporated skim milk, canned
1 tsp	vanilla extract
3 cups	sweet potatoes (cooked and mashed)



1. Preheat oven to 350° F.

Crust:

2. Combine the flour and sugar in a bowl.
3. Add milk and oil to the flour mixture.
4. Stir with fork until well mixed and then form pastry into a smooth ball with your hands.
5. Roll the ball between two 12-inch squares of waxed paper using short, brisk strokes until pastry reaches edge of paper.
6. Peel off top paper and invert crust into pie plate.



Beverage and Desserts

Filling:

7. Combine sugars, salt, spices, and eggs.
8. Add milk and vanilla. Stir.
9. Add sweet potatoes and mix well.
10. Pour mixture into pie shell.
11. Bake for 60 minutes or until crust is golden brown. Cool and cut into 16 slices.



Makes 16 servings
Serving size: 1 slice
Calories 147
Fat 3 g
Saturated fat less than 1 g
Cholesterol 40 mg
Sodium 98 mg

Beverage and Desserts

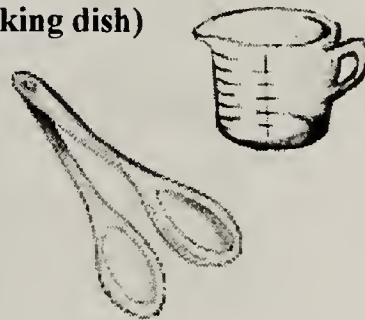
1-2-3 PEACH COBBLER

1/2 tsp	cinnamon, ground
1 Tbsp	vanilla extract
2 Tbsps	cornstarch
1 cup	peach nectar
1/4 cup	pineapple juice or peach juice (can use juice reserved from canned peaches)
2 16-oz cans	peaches, sliced, packed in juice, drained (or 1-3/4 lbs) fresh
1 Tbsp	margarine, tub nonstick cooking oil spray (for baking dish)
1 cup	pancake mix, dry
2/3 cup	all-purpose flour
1/2 cup	sugar
2/3 cup	evaporated skim milk

*Cooking oil spray helps to
coat the pan with little fat
or calories.*

Topping:

1/2 tsp	nutmeg
1 Tbsp	brown sugar



1. Combine cinnamon, vanilla, cornstarch, peach nectar, and pineapple or peach juice in a saucepan over medium heat. Stir constantly until mixture thickens and bubbles.
2. Add sliced peaches to mixture.
3. Reduce heat and simmer for 5 to 10 minutes.
4. In another saucepan melt margarine and set aside.
5. Lightly spray an 8-inch square glass dish with cooking oil spray. Pour hot peach mixture into the dish.
6. In another bowl, combine pancake mix, flour, sugar, and melted margarine. Stir in milk.

Beverage and Desserts

7. Quickly spoon this mixture over peach mixture.
8. Combine nutmeg and brown sugar. Sprinkle mixture on top of batter.
9. Bake at 400° F for 15 to 20 minutes or until golden brown.
10. Cool and cut into 8 squares.



Makes 8 servings

Serving size: 1 square

Calories 271

Fat 4 g

Saturated fat less than 1 g

Cholesterol less than 1 mg

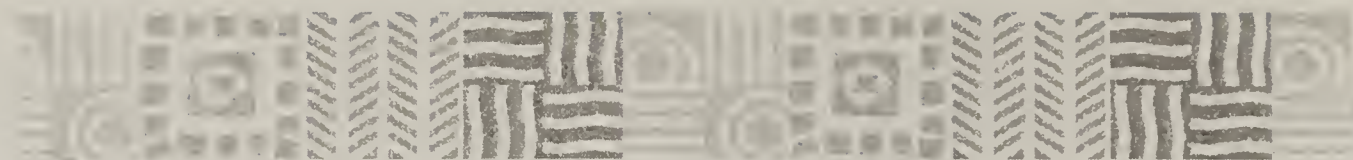
Sodium 263 mg





Recipes were analyzed using the
Minnesota Nutrition Data System
software—Food Database version
12A; Nutrient Database version
27—developed by the Nutrition
Coordinating Center, University of
Minnesota, Minneapolis, Minnesota.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
National Institutes of Health
National Heart, Lung, and Blood Institute

NIH Publication No. 97-3792
September 1997

愛惜 生命， 控制血糖 的步驟

Steps to Manage Your Diabetes



Chinese



Association of Asian Pacific Community Health Organizations

What is Diabetes?

People with diabetes cannot properly use the energy that is in the food they eat. Some of this food energy is turned into glucose (sugar). The pancreas, an organ near the stomach, makes a hormone called insulin to help glucose get into body cells. When you have diabetes, your body doesn't make enough insulin, or can't use its own insulin very well. This problem causes glucose to build up in your blood.

Taking good care of diabetes can lower the chances of getting:

- Eye disease that can lead to a loss of vision or even blindness
- Kidney disease and kidney failure
- Nerve damage that may cause a loss of feeling or pain in the hands, feet, legs, or other parts of the body and can lead to amputations
- Heart disease and heart attacks
- Stroke
- Dental problems

Every person who has diabetes has different needs. Talk to your doctor about a treatment plan that is best for you. When you have diabetes, managing it can help you live a long and active life.

These are the steps you can take to manage your diabetes. Take this brochure with you when you go to your doctor.



什麼是糖尿病？

糖尿病患者不能有效地吸收所吃食物作身體能源。通常，食物消化後分解成血糖。而胰臟製造的胰島素，幫助血糖進入我們的細胞。但是糖尿病患者卻缺乏胰島素，或不能有效地利用身體內的胰島素，這樣便使血糖積聚在血中。

控制血糖可減少以下情況發生：

- 糖尿病性眼病，這種病可使視力減退，甚至失明。
- 腎病及腎功能衰竭。
- 神經損害，這可使患者失去感覺，或有痛感，尤其在手、足、腿，或其他部位，嚴重的甚至可能要作手術去除某些部位。
- 心臟病或心臟病突發
- 中風
- 牙科毛病

糖尿病患者各有不同的需要，應與醫生商量選擇最適你的治療方法。當你患上了糖尿病，控制血糖能助你過上健康長壽的生活。

以下是一些控制血糖的方法和步驟，建議您在下一次見醫生時，攜帶這一份小冊子。

Find Out What Type of Diabetes You Have

There are different types of diabetes. If you have diabetes, ask your doctor if you have:

Type 1 diabetes. People who have this type of diabetes need to take insulin every day.

Type 2 diabetes. This type of diabetes can often be managed by controlling the kind of food you eat and by doing physical activity. Some people may also need to take diabetes pills or insulin.

Gestational diabetes. This type of diabetes occurs during pregnancy.

Many People Who Have Diabetes Do Not Know It

You may be at higher risk for diabetes than others if you have the following:

- Being older than 45
- Being overweight
- Having a close family member, like a parent, brother or sister, who has, or had, diabetes
- Having diabetes when you were pregnant (gestational diabetes)
- Being Asian American or Pacific Islander, African American, Hispanic/Latino, or Native American

要知道你患了那一種類型的糖尿病。

有幾種類型的糖尿病，若你是糖尿病患者，問醫生你是得了甲型還是乙型糖尿病。

甲型糖尿病：此類患者每天都需要注射胰島素。

乙型糖尿病：此類患者可以用控制食物及適當活動來控制血糖，有些人亦需要糖尿病藥物或注射胰島素。

懷孕期糖尿病：此類糖尿病只在懷孕期才發生。

很多人患有糖尿病都不自知。以下的人較容易患有糖尿病。

- 四十五歲以上
- 過重的人
- 有一近親有糖尿病，如父母，兄弟或姐妹
- 曾在懷孕期間有糖尿病
- 亞裔或太平洋島裔，黑人，西班牙裔美國人，美國印地安人

Get Regular Care for Your Diabetes

You deserve to get the best health care to help you manage your diabetes.

You should:

- Be able to get your health care needs taken care of regardless of your race, age, disability ability to pay, or immigration status.
- See a doctor, diabetes educator, and/or a nutritionist on a regular basis.
- Work with your health care team to make changes in your treatment plan when needed.
- Get support from family, friends, co-workers, and, if possible, other people with diabetes
- Be able to get help to pay for diabetes supplies, such as a blood glucose monitor, if you are on Medicare.

爭取定期的糖尿科照顧

你應該得到最好的醫療照顧，以便幫你控制血糖。

你應該：

- 不管你屬於哪一個種族，多大年齡，有否殘疾障礙，有無繳交醫療費用的能力，也不管你是什麼移民身分，你都應該得到合適的醫療照顧。
- 定期見醫生，糖尿病教育員和／或營養師
- 諮詢醫療人員，以便在有必要時及時改變治療方案
- 爭取家人，友人，同事及其他患者的支持
- 有聯邦醫療卡人士，則更可得到該卡規定範圍內的幫助，例如得到藥物，自用驗血糖機等。



Learn How to Manage Your Diabetes

Your doctor and your health care team can provide you and your family with correct information and help you learn how to manage your diabetes.

Do you:

- Know what type of exercise is best for you?
- Exercise regularly?
- Know what foods are healthy?
- Eat a healthy diet?
- Test your own blood sugar regularly?
- Take your medicine correctly?
- See your doctor regularly?
- Ask your doctor questions about your diabetes?

You should be doing all of these things in order to manage your diabetes.

Your doctor is not the only health care professional who can help you with your diabetes. Ask your doctor to help you set up an appointment with:

Eye Doctor (Ophthalmologist, Optometrist)

Foot Doctor (Podiatrist)

Diabetes Educator

Dietitian

Dentist

Counselor

Community Health Worker

These people, along with your doctor, are your health care team. They can help you make a plan for you to manage your diabetes. Having your own plan that fits with your life can help you stay healthy.



學會怎樣控制糖尿病

你的醫生及醫療人員可給你及你的家人提供正確的資料並幫助你學習控制糖尿病

你是否：

- 知道最合適你的運動
- 日日按時運動
- 知道什麼是有益於你的健康的食物
- 吃有益於你的健康食物
- 按時自驗血糖
- 正確使用藥物
- 定期見醫生
- 與醫生討論你的糖尿病

你應該做上列所有的事，幫助控制糖尿病。

除了醫生外，其他醫療人員亦可幫助你。請醫生護士幫助你約見以下人員：

眼科醫生(驗鏡醫生，眼專科醫生)

- 足科醫生
- 糖尿病健康教育員
- 營養師
- 牙科醫生
- 輔導師
- 社區健康工作者

以上人員可以與醫生合作照顧你，他們可幫助你設計適合你的治療方法。若能有良好的計劃配合你的生活習慣，可幫助你保持健康。

Control Your Blood Sugar Levels

The number one goal of diabetes treatment is to control your blood sugar levels. You must control your blood sugar levels to prevent problems such as eye disease, kidney disease, nerve damage, heart disease, and stroke. There are many ways that this can be done. These include:

- Eat a healthy diet
- Get regular physical activity
- Take medicine correctly
- See your doctor regularly
- Test your own blood sugar regularly

Work with your health care team to find the best way for you to control your blood sugar levels.

Test Your Own Blood Sugar

You should test your own blood sugar on a regular basis to help you manage your diabetes. This test is very important because it tells you how well you are controlling your blood sugar level throughout the day.

Your doctor and health care team can help you learn:

- What type of test to use
- How to do the test correctly
- How often to test
- How often to report the test results
- How to get the supplies you need to do the tests.

Ask your doctor for a Hemoglobin A1c Test

This test is not the same blood test you give yourself. This test is very important because it tells how well you have controlled your blood sugar over the last 2 to 3 months.

控制血糖水平

第一個治療目的是控制血糖。你一定要控制血糖而預防眼病，腎病，神經損害，心臟病及中風。有很多方法，包括：

- 吃有益健康的食物
- 按時每天運動
- 正確地用藥
- 按期見醫生
- 按期自驗血糖

請與你的醫療人員合作決定，找出最適合你的病情的控制血糖方法。

在家自驗血糖

按期自驗血糖能助你控制血糖，這驗血是很重要的，因為他可以讓你你知道你控制血糖的努力成效任何。

你的醫生及醫療人員可幫助你學習：

- 用那種方法驗血糖
- 怎樣正確地自驗血糖
- 每隔多久驗一次血糖
- 每隔多久向醫療人員報告一次驗血結果
- 怎樣得到自驗血糖的用品

請教你的醫生，什麼時候應該進行“血紅素血糖驗血 (Hemoglobin A1c Test)

這項驗血不同於自驗血糖。這種驗血檢查是十分重要的，因它可以看出，過去兩三個月內，你控制血糖的成績。

Get Checked for Long-Term Problems and Learn How to Prevent and Treat Them

To check for problems that diabetes can cause, you should see your doctor and your health care team regularly. Doing this can prevent problems or find them early, when they can be treated and managed well.

Talk to your doctor and health care team about how often you should get these tests.

- Blood pressure checks
- Cholesterol tests
- Other blood fat tests
- Foot exams
- Eye exams
- Kidney tests
- Dental exams

請檢查身體情況，可預防及治療長期的併發疾病。

因為糖尿病可引併發症，所以應定期見醫生，及早預防、診斷、醫治及控制這些毛病。詢問你的醫生應該多久作一次以下的檢查：

- 血壓
- 膽固醇
- 其他血脂肪檢驗
- 足科
- 眼專科
- 腎科
- 牙科



To take good care of your diabetes, be sure to follow these 5 steps:

1. Find Out What Type of Diabetes You Have.
2. Get Regular Care for Your Diabetes
3. Learn How to Manage Your Diabetes.
4. Control Your Blood Sugar Levels.
5. Get Checked for Long-Term Problems and Learn How to Prevent and Treat Them.

Remember, even if you have diabetes, by keeping your blood sugar levels under control, you can expect to live a long and active life.

控制糖尿病五步曲：

1. 知道你患了那一種類型的糖尿病
2. 得到定期的糖尿科照顧
3. 學習怎樣控制糖尿病
4. 控制血糖水平
5. 檢查身體情況，學習預防和及早治療長期的併發症

請記住，就算你患上了糖尿病，把血糖控制在一定程度內，你照樣可以過上健康長壽的生活。



Developed by Association of Asian Pacific Community Health Organizations. The contents have been modified from NIH Publication No. 98-4343L and Centers for Disease Control and Prevention, *Take Charge of Your Diabetes. Hawaii Revised Edition 1999*, Department of Health and Human Services. This publication was made possible by Alpha Gamma Delta and grant number U58/CCU916414 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of AAPCHO and do not necessarily represent the official view of CDC.

亞太裔社區健康組織協會提供。內容是經過 NIH Publication No. 98-4343L 和美國疾病預防與控制中心的《對你自己的糖尿病負責，一九九九年夏威夷修改版》健康部門和人力署修改。這個出版是得到 Alpha Gamma Delta 和美國疾病預防與控制中心的基金批准號碼 U58/CCU916414 贊助。所有內容是由亞太裔社區健康組織協會負責，並不代表美國疾病預防與控制中心的觀點。

Family Literacy EL Civics Health Awareness Curriculum of Fairfax County, Virginia, Adult & Community Education (ACE)!

The curriculum was designed for use in adult ESOL family literacy classes.

Content

 Lesson 1: Talking with the Doctor

Lesson 2: Asking Questions About Medicine

Lesson 3: Medication Warning Labels

 Lesson 4: Coping with Stress

**Family Literacy Curriculum
Health Module
Medicine and Stress**

Purpose:

Learners will practice asking the doctor questions to clarify instructions for taking medicine. They will read medication warning labels and analyze the warning labels they see on medicine at home. They will also explore the effects of stress and ways to manage it.



Lesson 1: Talking with the Doctor

Lesson 2: Asking Questions About Medicine

Lesson 3: Medication Warning Labels



Lesson 4: Coping with Stress

Lesson 1: Talking with the Doctor

Life Skills:

Learners will . . .

- Recognize the importance of asking for clarification at the doctor's office.
- Understand that they have the right as a medical patient to ask for an interpreter.

Technology Skills:

Learners will . . .

- Explore an Internet site with activities for English practice.
- Use pull-down menus to select different pieces of information.
- Practice speaking English with conversation prompts from a Web site.

Language Skills:

Learners will . . .

- Use a sequence of pictures to create a story orally.
- Write a story from a spoken narrative.
- Problem-solve ways that a character with little English can communicate with a doctor.
- Practice describing symptoms to a doctor.

Literacy Skills:

Literacy learners will . . .

- Learn vocabulary.
- Follow the sequence of events in a story.

EFF Skills:

Learners will . . .

- Solve problems.
- Reflect and evaluate.
- Cooperate with others.

Word Bank:

health care provider - general name used in the health care system for **doctor**, **nurse**, **nurse practitioner**, etc.; the person who helps you when you are in the hospital or clinic.

patient - the sick person who goes to the clinic or hospital

interpreter - someone who can change English to your language for you.

responsibility - something you need to do, like taking care of your children or paying your bills.

prescription - when the doctor gives you a paper for medicine. You take it to the pharmacy to buy the medicine.

confused - when you don't understand something or you don't know what to do.

nervous - afraid, scared (you can pantomime chewing your fingernails)

instructions - how to do something, like how many pills to take, and what time to take them.

Materials Needed:

Handouts of the picture story "A Doctor's Appointment" (print these from the Internet, at <http://www.cal.org/ncle/health/pdf/doctor.pdf>)

A board or flip chart

Chalk or markers

Computers with Internet access

Presenting the Concepts:

1. Ask the students if they have been to the doctor in the United States. Did they see a doctor, nurse, or nurse practitioner?
2. If students say that they have been to the doctor, ask if they spoke English with the health care provider. What was it like? Easy? Difficult? Confusing? Ask for examples.
3. Tell the students that today the class is going to write a story about someone who doesn't speak much English. The person is going to the doctor.

Activity 1: Language Experience Approach Story (LEA), "A Doctor's Appointment"**Note**

Before you begin this activity, read the suggested procedure for conducting an LEA lesson at <http://www.cal.org/ncle/health/> under "How can the stories be used in class?"; then read the detailed background information lesson ideas for the picture story, "A Doctor's Appointment."

1. Distribute copies of the picture story handout, "A Doctor's Story" (copyright 2001 by Kate Singleton; you can print copies from the NCLE Web site at the URL <http://www.cal.org/ncle/health/pdf/doctor.pdf>). Tell students that they will look at the pictures and tell this story together; then you will write the story on the board.
2. Follow the directions on the NCLE Web page for using the picture story in class (<http://www.cal.org/ncle/health/>).

**Extra practice for beginners**

Although the Web page gives question prompts for the story that are appropriate for low beginners, a simpler expansion of the discussion for Frame 8 could go as follows:

- *Did this happen to you?*
- *What can the man do? Or, What should he do?*
- *What can someone do at the doctor if they don't speak much English?*

3. As you discuss the picture story, keep in mind the following tips:

- You can give out information about students' rights and what interpreting services there are. For current information, call the local health department or low-cost clinic for accurate information. The Fairfax County Health Department and clinic phone numbers are listed at <http://www.co.fairfax.va.us/service/hd/hdclinicsite.htm>
- You can explain that language banks exist (but some doctors don't want to use them because they cost money for the doctor). It's not easy, but there are options. Examples of explanations:
 - In the United States, the doctor should help you understand in your language. It's the law. The government says the doctor should help you understand.
 - At the [insert name] Clinic, interpreters speak Spanish, Arabic and Vietnamese.
 - Sometimes, the doctor will call an interpreter on the telephone. Maybe yes, maybe no. You need to ask the doctor.
- Ask students if they have other suggestions. Some might suggest taking a friend or family member who speaks more English. This is okay, but a topic for further discussion might be whether or not it is ok for children to interpret about their parents' health (e.g., "Is it okay for children to speak English with the doctor when their mother or father is sick? ") Other students might suggest finding a doctor who speaks their language. This helps some people, but not those with no doctors in the area from their culture. Some students are happy with doctors who speak their language, and others report that doctors they've seen who speak their language see too many patients to give good care.
- There is no perfect answer, but it is important to know the law and present options!
- Ask students, "Is it okay to ask the doctor questions in your country? In the United States?" Mention that in the United States, you should ask the doctor questions. Say, "The doctors work fast and see many patients, so it's important to ask questions to make sure you understand what the problem is and what you should do."

4. After the story is written, give students time to practice reading and pronouncing difficult words. Have the whole class read aloud, allow volunteers to read aloud, and have students read to a partner as you circulate and assist.

Literacy students

Because the LEA activity is beneficial to literacy students, they should participate in the full-class activity. In the final phase of the activity, they can copy the story as it is written on the board. As class members read the story aloud, have the aide point to the corresponding words on the literacy students' paper.



Activity 2: Computer Prompts for Talking to the Doctor



Note

Before you begin this activity, you will need to set Internet browsers to the Web site of "Interesting Things for ESL Students." Go to the Web site (<http://www.manythings.org>), click "Travel Survival" (under the "Experimental" menu), and then click "Health Care." Or, go directly to the following URL:

<http://www.manythings.org/ts/health.html>

1. Explain to students that you are going to practice talking to the doctor. Have everyone look at the top of the Web page, where it says "Useful Expressions."
2. Ask for some student volunteers to come to the front of the room.
3. Have students take turns reading aloud each sentence in the first pull-down menu (e.g., "I have a headache"). As a student says the sentence, the student volunteers at the front of the room should act out the sentence (e.g., hold their head and moan in pain as they pretend to have a headache). Then the rest of the students should repeat the sentence aloud.
4. When you have gone through the items in the menu, have students work in pairs, taking turns reading and acting out symptoms in the menu (e.g., one partner reads the symptom; the other pantomimes it).



Workout for intermediate students

Intermediate students can take turns reading and acting out the second set of symptoms, which are a little more complex (e.g., "I cut my finger," "I was stung by a bee.")



Parent-Child Activity: Simon Says

To reinforce vocabulary pertaining to body parts, have parents and children play the game "Simon Says."

1. If you have a set of *The Oxford Picture Dictionary*, look at pp. 74-74 and read through the parts of the body.
2. Then have everyone close the dictionary; point to different parts of your body and elicit the corresponding vocabulary terms from students.
3. Explain the rules of the children's game "Simon Says." Play the game with students; the student who wins the game acts as Simon in the next game.



Lesson 2: Asking Questions About Medicine

Life Skills:

Learners will . . .

- Recognize the importance of asking the doctor questions about medicine.
- Understand the concept of "side effects" of medicine.

Language Skills:

Learners will . . .

- Acquire vocabulary related to side effects of medicine.
- Sequence and practice conversations about medication directions.
- Ask the doctor questions about medication.
- Comprehend spoken answers about medication.

Literacy Skills:

Literacy learners will . . .

- Pick out identical words in a series
- Write health-related vocabulary with the initial consonants "f" and "n" and begin to grasp sound-symbol correspondence.

EFF Skills:

Learners will . . .

- Speak so others can understand.
- Listen actively.
- Guide others.

Word Bank:

Side effects (i.e., extra problems you get when you take medicine)

(Note: Most of the side effects listed below are perhaps best demonstrated with pantomime rather than verbal explanation. If you feel there are too many for your students, choose the ones you feel will be most useful for them.)

Upset stomach, diarrhea, vomiting, rash, difficulty breathing, fatigue, headache, shaking

Materials Needed:

Flip chart or board and markers

Handout 1: Important Questions About Your Prescription

Handout 2: Important Questions About Your Prescription (Answer Key)

Handout 3: Question Strips (one copy for each pair; cut the copies into strips)

Handout 4: Answer Strips 1 (one copy for each pair; cut the copies into strips)

Handout 5: Answer Strips 2 (one copy for each pair; cut the copies into strips)

Zip-lock bags; colored paper

Arthur's Chicken Pox (Brown, 1996)

For literacy students:

Handout 6: Matching Terms for Body Parts

Handout 7: Body Parts with "F" and "N"

Presenting the Concepts:

1. Ask students if they have taken a prescription medicine before. Ask what information they needed to know about the medicine before taking it (e.g., how many times a day you take the medicine). On the board, list any questions they come up with.
2. Explain that in the United States, it is important to ask the doctor questions about medicine. Many people who don't speak much English make mistakes when they take medicine, and they can have big problems because they don't know the correct information.
3. Tell students that today they will practice questions and answers about taking medicine.



Literacy students

*As the other student complete the activity that follows, you or the aide can conduct a pullout session to help literacy students recognize by sight the terms for several body parts. Give students **Handout 6: Matching Terms for Body Parts**. Read through the terms at the left, with the students repeating them. Then have students find the word in the series that is identical to the word at the left and circle it. When they have finished, read aloud the words at the left again.*

Activity 1: Learning Questions

1. Give each student a copy of **Handout 1: Important Questions About Your Prescription**. An answer key is included in **Handout 2: Important Questions About Your Prescription (Answer Key)**.
2. Have students look at the questions in small groups to see what they already know or don't know. Encourage students to ask questions in their groups or provide clarification for others.
3. When students have had time to look over the paper, go through the questions one by one with the class.
4. Do choral pronunciation practice and check students' understanding of the questions. Ask students what a good answer for each question would be. (An answer key is provided for the handout.)
5. Write answers on the board for students to copy on their papers.
6. Have students repeat questions and answers after you, as a whole.
7. Have students practice in pairs, playing the roles of doctor and patient.
8. Ask for volunteers to present their dialogue to the class.



Workout for intermediate students

Intermediate students can do a "half-blind" practice of the dialogue; that is, the student playing the patient has to ask the doctor questions without looking at the script of the dialogue. The student playing the doctor can look at the script when saying the answers. Then they should switch roles. Emphasize that this practice is important so that students can remember the questions the next time they visit a doctor.

Literacy students

When literacy students complete the previous activity, they can work on the following exercises with the aide to help develop phonic awareness.

- *Give students **Handout 7: Body Parts with "F" and "N"**.*
- *Look at the "F" words. Say the "F" sound and then say the words on the handout that start with F. As you say each word, point to the body part; have students repeat the word several times.*
- *Next, students should fill in the missing initial consonant. Then they should copy the word.*
- *Repeat the previous steps with the "N" words.*
- *For homework, ask students to copy all of the words in their notebook.*

Activity 2: Matching Game

Note

*Before you begin this activity, you need to copy each of the three handouts (**Handout 3: Question Strips**; **Handout 4: Answer Strips 1**; **Handout 5: Answer Strips 2**) onto a different color of paper. Then cut each handout copy into strips. Place each set of strips in an envelope or Zip-Lock bag. Each small group or pair needs one set of question strips and two sets of answer strips.*

1. Have beginner students work in small groups of three or four; have intermediate students work in pairs.
2. Give each pair or small group a set of **Handout 3: Question Strips** and **Handout 4: Answer Strips 1**. You may want to ask if anyone knows the drug Claritin and what it is for.
3. Have students match questions with appropriate answers. As students finish, they can practice reading the strips aloud and copy the conversation in their notebooks. Then give them a set of **Handout 5: Answer Strips 2**; they should repeat the activity with the new answer strips.
4. When all students have finished, go over the pronunciation and vocabulary of each set of strips.

Workout for intermediate students

Encourage intermediate students working in pairs to ask their partner the questions on the question strips. The student with the answer strips has to listen

to the questions (without seeing them on the strips) and read the answers on his strips. Then they can switch roles and repeat the exercise.



Parent-Child Activity: Story Reading, *Arthur's Chicken Pox*

Do a story reading with the children's book *Arthur's Chicken Pox* (Brown, 1996) to talk about what happens when a child is sick.

Activity steps:

1. Have everyone sit in a circle (on the floor if necessary) and explain that you will read a book together about a little boy who gets the chicken pox.
2. Ask the children if any of them have had the chicken pox. What was it like? With the children's help, explain to the parents what the chicken pox is and how you feel when you have it (i.e., itchy!).
3. Go through the illustrations in the book, page by page, and ask parents and children what they see in the pictures. Do not read the book yet; the idea is to elicit language and to model to parents how they can share a book with children without having to read the words.
4. Read the story aloud, page by page, pointing to the words in the pictures as you say them.
5. Ask, "Why does Arthur's sister make fun of his 'polka dots' and pretend to be sick?" If necessary, explain that D.W. is jealous of the attention that Arthur is getting because he is sick. Ask the children if any of them have ever gotten extra attention when they were sick.
6. Tell everyone, "Then something happened to D.W. What happened?" (i.e., then she got sick and couldn't go to the circus with the family -- even though Arthur was better now and could go to the circus).
7. Say, "Let's talk for a few minutes about Arthur. What do his parents do for him when he is sick?" Elicit examples (e.g., give him a bath, let him eat dinner on the couch, rub his back, etc.).
8. Ask the children, "Do your parents do special things for you when you are sick? What do they do?" Discuss the examples. Then ask parents what *their* parents did for them when they were children and they were sick.
9. Explain to parents that it helps their children to look at books and talk about them -- in any language. They can read a book together, or they can look at the pictures and talk about the story.
10. Tell parents that their "homework" is to look at a book with their child.

11. If your site has a lending library of book and cassette sets, introduce parents to it (if you haven't already done so), showing them how to "check out" a set. Invite parents and children to select a set to bring home for the week.

HANDOUT 1: Important Questions About Your Prescription

1. What is this medicine?

2. What is it for?

3. How many should I take?

4. How long do I need to take it?

5. When will I feel better?

6. What are side effects of the medicine?

HANDOUT 2: Important Questions About Your Prescription (Answer Key)

1. What is this medicine?

It is erythromycin (for example).

2. What is it for?

It's for bronchitis. (It's for an infection.)

3. How many should I take?

Take 1 pill every 6 hours. Take 4 a day. Take it 1 hour before you eat.

(Use as much or as little of this information as your students can handle.)

4. How long do I need to take it?

For 2 weeks. Don't stop before 2 weeks.

5. When will I feel better?

You should feel better in 3 days. If you don't feel better, call me.

6. What are side effects of the medicine?

Examples of simple side effects to present through pantomime are: upset stomach, vomiting, rash, difficulty breathing, fatigue, headache, shaking. (Again, you can decide how much your students will understand and absorb.)



What is this medicine?

What is it for?

How many should I take?

How long do I need to take it?

When will I feel better?

What are side effects of the medicine?



It's Claritin.

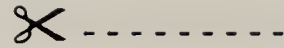
It's for allergies and hay fever.

One a day.

For the spring and summer.

In 3 days.

**Maybe you'll have a headache
or you'll feel sleepy.**



It's Prevacid.

It's for pain in your stomach.

One a day, before you eat.

For one month.

In a week.

**Maybe you'll have vomiting
or diarrhea.**

HANDOUT 6: Matching Terms for Body Parts

foot	flute	font	foot
finger	finder	finger	linger
head	hand	hear	head
hand	hand	sand	hind
neck	make	neck	next
nose	most	nest	nose
back	rack	back	book
leg	leg	let	lad

HANDOUT 7: Body Parts with "F" and "N"

F

___oot

___inger

N

___ose

___eck

Lesson 3: Medication Warning Labels

Life Skills:

Learners will . . .

- Become more aware of medication safety by learning to read and understand warning labels.
- Complete a Medication Warnings Project that calls for them to look at the medications at home and note and analyze the warning labels on them.

Language Skills:

Learners will . . .

- Acquire basic vocabulary needed to understand medicine sticker warnings.
- Read label drug information to understand medication better.
- Practice affirmative and negative forms of imperatives.

Literacy Skills:

Literacy learners will . . .

- Write health-related vocabulary with the initial consonants "h," "b," and "l" and begin to grasp sound-symbol correspondence.

EFF Skills:

Learners will . . .

- Read with understanding.
- Reflect and evaluate.
- Cooperate with others.

Word Bank:

(Note: The use of warning stickers is regulated by individual state governments, so language and mandated content differs from state to state. Virginia Code does not specify what language is to be used. The vocabulary in this lesson has been selected as representative of typical warning labels.)

Chew, crush, swallow, shake, plenty of, pregnant, drowsiness, dizziness, alcoholic beverages, avoid

Materials Needed:

Flip chart or board and markers

(If possible) Ask a pharmacist for warning stickers and/or empty prescription bottles, or bring in empty ones from home with the prescription label removed

(If possible) Empty over-the-counter medication containers

*(Note: You'll need to make sets for **Handout 8 and Handout 9**; each small group or pair of students will need one set of explanation cards and one set of warning cards. To keep the sets together, you can store them in Zip-Lock bags.)*

Handout 8: Warning Stickers

Handout 9: Warning Explanations

Handout 10: Taking Medications 1 (cut each copy in half)

Handout 11: Taking Medications 2 (cut each copy in half)

Handout 12: Medication Warnings (cut each copy in half)

Zip-lock bags

For literacy students:

Handout 13: Body Parts with "H," "B," and "L"

Handout 14: Initial Consonant Review

Presenting the Concepts:

1. Tell students that you will be talking about taking medications today. Ask them what medications they know and list them on the board. Ask what the medications are for (e.g., aspirin is for a headache, fever, etc.)
2. Ask students where you get medications (the pharmacy). Talk briefly about the difference between prescription medications (need to get permission from a doctor before going to the pharmacy to buy it) and "over the counter" medications (can buy at the pharmacy without the doctor's prescription). Write these terms on the board.
3. Ask if anyone ever had a problem from taking medicine. Did a medication ever make someone sick? Say, "Sometimes, if you are not careful, medications can make problems."

 Literacy students

As the other students complete the activities that follow, you or the aide can conduct a pullout session to help literacy students recognize by sight and write the terms for body parts beginning with "H," "B," and "L."

- *Review the words students practiced in the last two lessons, with the "F" and "N" initial consonants.*
- *Give students **Handout 13: Body Parts with "H," "B," and "L"**.*
- *Look at the "H" words. Say the "H" sound and then say the words on the handout that start with H. As you say each word, point to the body part; have students repeat the word several times.*
- *Next, have students fill in the missing initial consonant ("H"). Then they should copy the "H" words.*
- *Students should repeat the previous steps with the "B" word and then with the "L" word.*
- *Together or for homework, have students fill in the missing initial consonants on **Handout 14: Initial Consonant Review handout**. You can do this as a dictation, with you reading the words and the student writing the missing letters -- or as a homework exercise, with students looking at their classwork and copying the missing letters.*

Activity 1: Recognizing Warning Stickers

1. Tell students that the class will now talk about warnings on prescription medications. Write "warning" on the board and see if anyone can explain it. If necessary, you can tell them it is the same as "Be careful! "

2. Tell the students that prescriptions have warning stickers on them. Show them examples of labels from the pharmacy or home. If some are familiar with the labels, ask for examples of the warnings. If necessary for your class, introduce the words in the Word Bank. Pantomime may be an effective way for you to demonstrate these words; then students can practice them by acting them out as well.

3. Using **Handout 8: Warning Stickers**, write the warnings on the board, one by one. As you write each one, discuss what it means and ask if anyone has seen it before on a medicine bottle. Help students practice pronunciation of key words.

4. Put intermediate students in pairs; put beginning students in small groups.

5. Give each pair or group a set of sticker cards (made from **Handout 8: Warning Stickers**). Have students read the sticker cards together and discuss what they mean. Then give each pair or group a set of the explanation cards (made from **Handout 9: Warning Explanations**). Have students read the explanation cards together and then match one explanation to one sticker card.

6. When students have matched the cards correctly, they can copy any pairs that they didn't know.



Workout for intermediate students

Partners who finish early can play face-up or face-down concentration with the card sets. Or, one partner can read the warning sticker cards aloud while the other partner looks at the explanation cards and points to the corresponding one.

Activity 2: Pair Listening Dictations

1. Have students form pairs. In each pair, give Partner A **Handout 10: Taking Medications 1**; give Partner B **Handout 11: Taking Medications 2**.

2. Partner A should listen and write the missing words on **Handout 10**. Partner B should read the sentences.



Workout for intermediate students

Intermediate students who act as Partner A can do a full dictation. That is, they should not receive a copy of the handout; instead of filling in the missing words, they should write the full sentences that Partner B reads from the handout.

3. As pairs finish, have them switch roles and do the same exercise with **Handout 11**.



Extra practice for beginners

If beginners need extra pronunciation practice, read through the sentences aloud together, choral style. Next, have volunteers read individual sentences aloud.

Activity 3: Medication Warnings Project

1. Tell students that they have homework they need to complete before the next class.
2. Give everyone a copy of **Handout 12: Medication Warnings**. Explain that students should take look at their medications at home. On the handout, they should copy any warning stickers on the medicine.
3. Reiterate that students should **not** copy the names of medicine, because that is personal information.
4. Remind students to bring the handout to the next class.



Parent-Child Activity: "What Do You Do For . . . ?"

This activity helps reinforce the concepts students practiced in this class and the previous class. It also allows students to share folk remedies from their countries.

1. Write the following on the board:

What do you do for a . . .

headache?

stomachache?

toothache?

backache?

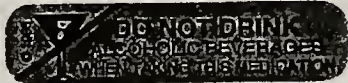
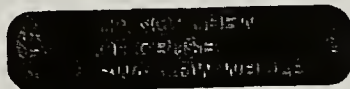
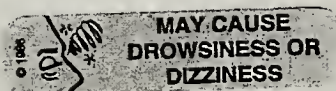
fever?

cold?

2. To make sure that everyone knows the vocabulary, have children pantomime each of the ailments listed on the board.
3. Divide parents and children into six groups. Assign each group one of the ailments listed on the board.
4. Explain that each group has to discuss what you do for the sickness; students can talk about what kind of medicine you take or what other things you do (e.g., stay in bed and rest if you have a fever). Emphasize that any answers are fine, be they traditional cures from students' native cultures (e.g., eating ginger for a stomachache) or mainstream U.S. treatments (e.g., taking aspirin for a headache).
5. Explain that the children in the group will draw a picture illustrating the ailment.
6. After each group has finished talking about the ailment and drawing pictures of it, have a representative from each group present the pictures and the group's treatment ideas. Discuss the ideas as a group and encourage students from other groups to share their home remedies.

HANDOUT: Warning Stickers



HANDOUT 9: Warning Explanations ✂

This medicine is for your skin only. Don't eat it!	Do not drink beer with this medicine.
Drink a lot of water with this medicine.	Eat food with this medicine.
Move the medicine fast in your hands to mix it.	Don't take the medicine if you are going to have a baby.
Put the medicine in your eyes only.	Do not break the medicine with your hand or teeth. Eat it all together, in one piece.
Maybe you will feel sleepy when you take this medicine.	Don't eat food when you take this medicine. After you eat, wait 2-3 hours before you take the medicine. Or take the medicine 1 hour before you eat.

HANDOUT 10: Taking Medications 1

Partner A

1. Drink _____ of water.
2. _____ food with this medication.
3. This medication is for your _____.
4. Shake the _____ well.
5. Do not _____ with this medication.



Partner B

1. Drink plenty of water.
2. Eat food with this medication.
3. This medication is for your eye.
4. Shake the medication well.
5. Do not drink with this medication.

HANDOUT 11: Taking Medications 2

Partner A

1. If you are pregnant, don't _____ this medication.
2. Maybe you will feel _____, or drowsy.
3. _____ eat food when you take this medicine.
4. Do not _____ the medication.
5. This medicine is _____ your skin.



Partner B

1. If you are pregnant, don't take this medication.
2. Maybe you will feel sleepy, or drowsy.
3. Don't eat food when you take this medicine.
4. Do not chew the medication.
5. This medicine is for your skin.

HANDOUT 12: Medication Warnings

What warnings are on medications at home? Write them here.



What warnings are on medications at home? Write them here.

HANDOUT 13: Body Parts with "H," "B," and "L"

H

__and

__ead

B

__ack

L

__eg

HANDOUT 14: Initial Consonant Review

_____ oot

_____ inger

_____ ead

_____ and

_____ eck

_____ ose

_____ ack

_____ eg

Lesson 4: Coping with Stress

Life Skills:

Learners will . . .

- Analyze what stress is and how to alleviate it.

Technology Skills:

Learners will . . .

- Open an Internet document and read a picture story on the Web.

Language Skills:

Learners will . . .

- Read a story about a character who is under a lot of stress.
- Discuss ways to alleviate stress.
- Write tips for managing stress.
- Look at a picture story and tell the story, describing the sequence of events.
- Acquire vocabulary related to feelings.

Literacy Skills:

Literacy learners will . . .

- Acquire vocabulary.
- Explore the concept of words as units of a sentence.

EFF Skills:

Learners will . . .

- Speak so others can understand.
- Reflect and evaluate.
- Read with understanding.

Word Bank:

Stress, make time for yourself, Web site, scroll, link, "Back" button

Materials Needed:

Flip chart or board and markers

Handout 12: Medication Warnings (students should bring this completed handout with them; it was distributed in Lesson 3)

A copy of the *Stress* booklet (Gould, 2000) for each student or pair of students

Computers with word-processing and Internet access

Presenting the Concepts:

Note

*For this activity, students will need **Handout 12: Medicine Warnings** (from the Lesson 3).*

1. Have students look at **Handout 12: Medicine Warnings** (i.e., "What warnings are on medications at home?") distributed in the last class.
2. Ask what warnings students noted on the handout. Make a list on the board, discussing what each warning means.
3. Reiterate the idea that medication can make you sick if you're not careful.
4. Say that today, you're going to talk about something else that can make you sick: stress.

Literacy students

Because the Stress booklet (Gould, 2000) has a photo illustration on each page, literacy students can follow the activity. As you read the story aloud, you can have the aide point to each word on the page.

Activity 1: Ann's Story

1. Ask students if they know what stress is. Discuss the concept together, giving examples (e.g., "How do you feel when you have too much work to do?")
2. Tell students that they will now read a story about a woman who has a lot of stress in her life. Give each student or pair of students a copy of the booklet, *Stress* (Gould, 2000).
3. Read the story aloud one time as students listen.
4. Then have five students come to the front of the room. Assign each student one of the following roles:

Ann
Ann's son
Ann's boss
Ann's sister
Kim (Ann's friend)
5. Have the rest of the students read the story aloud together, page by page; after they read each page, have the student actors portray the action on that page.
6. Ask students the following comprehension questions:

- Why does Ann's son make Ann feel stress?

- Why does Ann's boss make Ann feel stress?
- Why does Ann's sister make Ann feel stress?
- What does Kim say Ann should do about the stress?

Activity 2: Discussion and Writing

1. Ask students, "What do you think about Kim's ideas? Are they good?" Discuss this together. Then ask, "Is there anything else Ann can do about the stress?"

2. Tell students, "Kim tells Ann nine things she can do about stress. What can Ann do?" Write the following prompts on the board:

Ann can make time for herself.

Ann can _____.

3. Give students a few minutes to complete the writing. Then make a list together on the board and read the sentences back aloud together.

Example:

Ann can go for a walk each day.

Ann can take a hot bath.

Ann can spend time with friends.

Ann can learn to say no.

Ann can make time for herself.

Ann can stop eat less junk food.

Ann can drink less coffee, beer, and wine.

Ann can drink more milk, coffee, and juice.

Ann can write her feelings in a book.



Literacy students

Literacy students can copy the sentence written on the board. Have the aide read it aloud several times, pointing to each word; then the aide can write two or three similar sentences and read them aloud, word by word, to help familiarize literacy students with the concept of words as units of a sentence. Then the aide should try and elicit similar sentences (beginning with "Ann can"), writing them down and having students read them back aloud.



Activity 3: Telling a Picture Story, "Stressed Out"



Note

Before you begin this activity, read the suggested procedure for conducting an LEA lesson at <http://www.cal.org/ncle/health/> under "How can the stories be used in class?" Then read the detailed background information lesson ideas for the picture story, "Stressed Out."

1. Bring students to the computer lab. Explain that they are now going to look at pictures of another person who is having a lot of stress. Tell students that they will look at the pictures and then tell the story together.

2. Have students go to the NCLE Web site and access the picture story, "Stressed Out" (copyright 2001 by Kate Singleton). To do so, ask students to double-click on the Internet browser; then they should type the following URL, and hit "Enter":

<http://www.cal.org/ncle/health/pdf/stressed.pdf>

3. Talk about what is happening in each frame of the picture story, using the prompts on the Internet (see <http://www.cal.org/ncle/health/#Stressed>). As you go through the frames, help students to scroll down the screen to see each set of pictures.

4. Discuss the story together, using these prompts that accompany the story:

- What are the woman's problems in the story?
- What can happen if she continues to have too much stress in her life?
(e.g. make mistakes at home and on job, physical illnesses, anger, depression, anxiety)
- What advice can you give the woman to have less stress in her life?
- What are some things that give you stress in your life?
- Can you change anything to feel less stress for yourself? What can you do?



Parent-Child Activity: Expressing Feelings

The following activity allows students to talk about some feelings that are similar to stress.

1. If you have a set of *The Oxford Picture Dictionary* (Shapiro & Adelson-Goldstein, 1998) look at pp. 31-32 and read through the feelings.

2. Have everyone close the dictionary. Write the following terms on the board:

hungry
sleepy
calm

nervous
happy
sad
angry
scared
surprised
tired
embarrassed
thirsty
sick
confused
bored
frustrated

3. Have students copy the terms. As they do so, you should copy each word on a tiny slip of paper. When you finish, put all the slips of paper into a hat or container.
4. Tell students that they are going to pick a feeling and act it out; then the other students have to guess what the feeling is.
5. Have a volunteer draw a slip of paper from the hat and act out the corresponding feeling. The parents and children should try and guess the feeling; the first one who says it correctly should draw another slip of paper from the hat and act out the feeling while the others guess.
6. Repeat the activity until students have pantomimed all of the feelings.

HEAL:BCC Curriculum



Developed by World Education in Cooperation
with the Centers for Disease Control and Prevention



Health Education and Adult Literacy
HEAL: Breast & Cervical Cancer
www.worlded.org/us/health/heal

Developed by World Education in Cooperation with
the Centers for Disease Control and Prevention

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HEAL:BCC Teacher Support

HEAL:BCC Word List - Ready to Copy

Passport to Health - Ready to Copy

Breast and Cervical Cancer Organizations and Contacts

Additional Resources and Materials

HEAL:BCC Publications Order Form

What Difference Does it Make? - Interview with a HEAL:BCC Teacher

Why Teach Health? - An Article

It's Not Just an Earache That I Have - An Article

HEAL:BCC and Pre-GED Skills Development

HEAL:BCC Web Site - <http://www.worlded.org/us/health/heal>

The HEAL:BCC Teacher Support for this curriculum is bound separately to make it easier for you to review and make copies.

Making Health Communication Programs Work

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service • National Institutes of Health
National Cancer Institute

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African American Curriculum

Empower Yourself! Learn Your Cholesterol Number

National Institutes of Health
National Heart, Lung, and Blood Institute
And Office of Research on Minority Health

Contents

[Should you be concerned about your blood cholesterol number?](#)

[What is blood cholesterol?](#)

[What are good and bad cholesterol?](#)

[Have your blood cholesterol checked.](#)

[Take action to keep your cholesterol number low. Follow these steps:](#)

Should you be concerned about your blood cholesterol number?

YES! High blood cholesterol increases your chances for coronary heart disease. Coronary heart disease is a disease of the blood vessels of the heart that causes a heart attack. It is the number one killer among African Americans. You can take steps to protect your heart! Read this brochure. Improve your cholesterol level or keep it at the right level to help reduce your risk of getting heart disease.

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What is blood cholesterol?

Your body makes all the cholesterol you need. Eating foods high in saturated fat and cholesterol can raise your blood cholesterol level. The higher your blood cholesterol level, the greater your risk for heart disease. Too much cholesterol can lead to clogged arteries. You are then at risk for having a heart attack, a stroke, or poor circulation.

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What are good and bad cholesterol?

HDL "good cholesterol" helps clean fat and cholesterol from arteries, carrying it to the liver for removal from the body. **LDL** "bad cholesterol" deposits cholesterol in your arteries and causes them to become clogged.

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..

Have your blood cholesterol checked.

All adults age 20 and older need to have their blood cholesterol checked at least once every 5 years. Ask your doctor to do a simple test to measure how much HDL and total cholesterol is in your blood.

Here's what your numbers mean.		
Total blood cholesterol		
Desirable:	Less than 200 mg/ dL.	Good for you! Try to keep it below this number.
Borderline:	200-239 mg/ dL.	Be on the alert! You are at risk for a heart attack. You need to make changes in your lifestyle.
High:	240 mg/ dL or higher.	Danger zone! You have a higher risk for a heart attack. Seek help from your doctor to lower your cholesterol level.
HDL-cholesterol	35 mg/ dL or higher.	Being physically active can help raise your HDL.

If the total blood cholesterol number is higher than 200, or if your HDL is lower than 35, your doctor may order blood tests to check your LDL cholesterol level. The test will let you know if you need treatment. Take charge and work with your health provider to lower your risk.

Here's what your number means.	
LDL cholesterol	
Desirable:	Less than 130 mg/ dL
Borderline:	130-159 mg/ dL
High:	160 mg/ dL or more

Take good care of yourself!			
My cholesterol levels:		Recommended goal:	
Total		Total	
HDL		HDL	
LDL		LDL	

Take action to keep your cholesterol number low. Follow these steps:

1. Eat foods low in saturated fat and cholesterol.

MEATS, POULTRY, AND FISH

Instead of:	Try:
High-fat meats	Lean meats, poultry without skin, fish Bean and grain dishes
Fatback and bacon	Skinless chicken or turkey thighs

CURED MEATS

Instead of:	Try:
Pork bacon	Turkey bacon, lean ham, Canadian bacon (These choices may be high in sodium. Read the label.)
Pork sausage, ground beef, and pork	Ground skinless turkey breast

DAIRY PRODUCTS

Instead of:	Try:
Whole milk	Skim (nonfat) or 1 percent milk
Whole milk cheeses	Low fat or part skim milk cheeses
Cream, evaporated milk	Evaporated skim milk
Sour cream	Low fat yogurt

FATS, SPREADS, AND DRESSINGS

Instead of:	Try:
Lard, butter, shortening	Small amounts of vegetable oil
Regular mayonnaise, regular salad dressing	Mustard and nonfat or low fat types of salad dressing, yogurt, or mayonnaise

2. Keep moving.

Do 30 minutes or more of physical activity most days of the week. You can do 10-minute sessions at different times during the day. Choose activities you enjoy. For example:

Walking jogging
Gardening bike riding
climbing stairs playing sports

3. Maintain a healthy weight.

Take steps to lose weight if you are overweight. Try losing weight slowly.

- Cut back on foods high in fat and calories. Use the food label to choose foods lower in fat and calories.
- Eat smaller portions.
- Eat fruits and vegetables at meals and for snacks.
- Bake, broil, roast, stew, or microwave your food instead of frying.
- Stay active every day.

Check the steps you will take for a healthy heart.

- Get my blood cholesterol level checked.
- Talk to my doctor about what my numbers mean.
- Bake chicken without the skin instead of frying it.
- Eat more fruits, vegetables, breads, and cereals.
- Eat smaller portions.
- Try to take a 10-minute walk in the morning, at lunch, and after work.

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U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service National Institutes of Health

National Heart, Lung, and Blood Institute

NIH Publication No. 97-4063

September 1997

Heart-Healthy Home Cooking: African American Style

National Heart, Lung, and Blood Institute; Office of Research on Minority Health, 1997

National Heart, Lung, and Blood Institute (NHLBI) Information Center

P.O. Box 30105

Bethesda, MD 20824-0105

PHONE (301) 592-8573

FAX (301) 592-8563

WEB This booklet: www.nhlbi.nih.gov/health/public/heart/other/chdblack/cooking.htm

Related information: <http://www.nhlbi.nih.gov/health/public/heart/index.htm>

Publication number 97-3792; \$2.50, bulk discounts available

This is a collection of 20 heart-healthy, African American recipes that are low in fat, saturated fat, cholesterol, and sodium. They are simply written, brief, and have pictures throughout. Each recipe includes the amounts per serving of calories, total fat, saturated fat, cholesterol, sodium, calcium, and iron.



BALANCE Program for Diabetes

Association of Asian Pacific Community Health Organizations (AAPCHO)

Recommended List of Diabetes-Related Educational Materials

Sorted by Topic

Introduction

In an effort to increase availability and access to scientifically accurate and culturally and linguistically appropriate diabetes-related educational materials for Asian Americans and Pacific Islanders (APIs) with limited English proficiency who are at risk for or living with diabetes, the BALANCE Program for Diabetes has collected and reviewed existing materials since 1999. The materials included in this list have been evaluated by teams of bilingual reviewers and have been included here based on reviewers' recommendations. The reviews and this document do not include all available AAPI diabetes-related educational materials, as new materials are produced regularly. If you have any questions about this process, or if you would like to submit a material for review, please contact the BALANCE Program at ewong@aapcho.org.

About AAPCHO

Established in 1987, the Association of Asian Pacific Community Health Organizations (AAPCHO) is a not-for-profit national association representing community health organizations primarily serving Asian Americans and Pacific Islanders (APIs) in the United States, particularly the medically underserved.

About BALANCE

The BALANCE (Building Awareness Locally and Nationally through Community Empowerment) Program for Diabetes is funded through a three-year cooperative agreement with the Centers for Disease Control and Prevention and is designed to work cooperatively with the National Diabetes Education Program.

Please visit www.aapcho.org for more information.

General Diabetes Information

Title (in alphabetical order)	Languages Recommended	Material Information	Source/Contact Information	Availability
Diabetes and You	Chinese	14 page book with illustrations covering the basics of diabetes care	Joslin Diabetes Center One Joslin Place Boston, MA 02215 (617) 732-2695 www.joslin.org	Purchase at: www.store.joslin.org
Type 2 Diabetes	Vietnamese	30 page spiral bound book containing general introduction to diabetes, covers physiology of diabetes and self-management	Nhan Hoa Clinic 14221 Euclid St. Ste. H Garden Grove, CA 92843 (714) 539-9999 www.nhanhoa.org	Contact source directly

Self-Care Information

Title (in alphabetical order)	Languages Recommended	Material Information	Source/Contact Information	Availability
Control Your Diabetes. For Life	Cambodian, Chamorro, Chinese, Gujarati, Hawaiian, Hindi, Hmong, Korean, Laotian, Samoan, Tagalog, Thai, Vietnamese	1 page multilingual flyer containing translation of phrase "Control your diabetes. For life" in languages listed	National Diabetes Education Program 1 Diabetes Way Bethesda, MD 20814-9692 (800) 438-5383 www.ndep.nih.gov	E-mail ndep@info.nih.gov
Diabetes and Foot Care	Chinese, English	1 page double-sided handout with 9 specific guidelines for foot care for people with diabetes	The Diabetes Care Center U. of Washington Medical Ctr 1959 NE Pacific Street Seattle, WA 98195 (206) 598-4963	Contact source directly
Diabetes and	Chinese	1 page pamphlet with	South Cove Community Health	Contact source

Your Feet		general foot care tips for people with diabetes	Center 885 Washington Street Boston, MA 02111 (617) 521-6700	directly
Diabetes Health Record	English, Farsi, Lao	Fold-up wallet card that maintains records of medical tests and personal goals, includes space to list medication and contact information for health care professionals	ADA CA Diabetes Control Program Diabetes Coalition of CA Juvenile Diabetes Foundation (916) 445-2547	Download at: http://www.caldiabetes.org/
Exercise and Diabetes	Cambodian, Vietnamese	1 page handout with suggestions for an exercise plan - what, how much, how hard	Harborview Medical Center 325 9th Avenue Seattle, WA 98104 (206) 731-3000	Download at: http://ethnomed.org/ethnomed/patiented/diabetes/diabetes_index.html
Living with Diabetes	Cambodian, English	5 pages of information about controlling diabetes in story format about insulin, food, exercise	Asian Health Project Health Promotion Council 260 South Broad Street Philadelphia, PA 19102-5085 (215) 731-6154	Contact source directly
Preventive Care Guidelines	English, Vietnamese	1 page double-sided handout discussing health care visits and tests for people with diabetes and possible complications that can be detected with regular doctor visits	The Diabetes Care Center University of Washington Medical Center 1959 NE Pacific Street Seattle, WA 98195 (206) 598-4963	Contact source directly
Samoan Diabetes	Samoan (with English translation)	15 page spiral bound book with information	Utah Diabetes Prevention and Control Program	Download at: http://www.health.ut

Manual		on types of diabetes, blood sugars testing, medication, social support, care for feet, physical activity, healthy food choices	PO Box 141010 Salt Lake City, UT 84114 (801) 538-6101	ah.gov/diabetes/resources/main/educationalmanuals.htm
Sick Days and Diabetes	Cambodian, Vietnamese	1 page handout with suggestions about extra steps to take when people with diabetes are sick	Harborview Medical Center 325 9th Avenue Seattle, WA 98104 206-731-3000	Download at: http://ethnomed.org/ethnomed/patient-ed/diabetes/diabetes_index.html
Staying Healthy with Diabetes: A Guide for the Chinese American Community	Chinese (with English translation)	85 page book with information on what is diabetes, signs, risks, complications, low & high blood glucose, sick days, exercise, extensive meal planning section	Joslin Diabetes Center One Joslin Place Boston, MA 02215 (617) 732-2695 www.joslin.org	Purchase at: www.store.joslin.org
Steps to Manage Your Diabetes	Chinese, Korean, Samoan, Tagalog, Vietnamese (all with English translation)	8 page booklet that provides a general introduction to diabetes and diabetes management	Association of Asian Pacific Community Health Organizations (AAPCHO) 439 23 rd Street Oakland, CA 94612 (510) 272-9536	Download at: www.aapcho.org
Take Care of Your Heart. Manage Your Diabetes	Cambodian, Chamorro, Chinese, Chuukese, English, Gujarati, Hindi, Hmong, Japanese, Korean, Lao, Samoan, Tagalog, Thai, Tongan, Vietnamese	1 page flyer that tells people with diabetes about the link between diabetes and heart disease, encourages them to manage their blood glucose, blood pressure, and	National Diabetes Education Program 1 Diabetes Way Bethesda, MD 20814-9692 (800) 438-5383 www.ndep.nih.gov	Download at: http://www.ndep.nih.gov

			cholesterol			
Tongan Diabetes Manual	Tongan (with English translation)	15 page spiral bound book with information on types of diabetes, blood sugars testing, medication, social support, care for feet, physical activity, healthy food choices	Utah Diabetes Prevention and Control Program PO Box 141010 Salt Lake City, UT 84114 (801) 538-6101	Download at: http://www.health.utah.gov/diabetes/resourcesmain/edmulticulturalmanuals.htm		
Video: A Healthy Life for Diabetic Patients	Chinese: Cantonese	12 minute video with general information on self-management of diabetes	Alta Bates Summit Medical Center 3100 Summit Street Oakland, CA 94609 (510) 869-8229	Contact source directly		
Video: Facing the Tiger	Vietnamese	Video aiming to increase the Vietnamese community's awareness of risk factors and symptoms of diabetes, includes real patients and their families (under 20 minutes)	Harris County Hospital District Texas Dept of Health Diabetes Program/Asian American Diabetes Education Project 2525 Holly Hall, Ste 187E Houston, TX 77054 (713)-566-6225	Contact source directly		

Nutrition

Title (in alphabetical order)	Languages Recommended	Material Information	Source/Contact Information	Availability
Asian American Diabetes and Nutrition Handbook	Chinese , Vietnamese (both with English translation)	13 page booklet with information on symptoms, complications,	Harris County Hospital District Texas Dept of Health Diabetes Program/Asian American Diabetes Education Project	Download at: http://www.tdh.state.tx.us/diabetes/publications/patient.htm

		management, stress, diet, nutrition	2525 Holly Hall, Ste 187E Houston, TX 77054 (713)-566-6225	
Asian Food Guide	Cambodian, Chinese, English, Laotian, Vietnamese	Trifold color brochure with food pyramid, food categories, examples and serving sizes	Sweet Success Material & Resource Center 4542 Ruffner Street, Suite 130 San Diego, CA 92111-2250 (858) 467-4990	Contact source directly
Diabetes Meal Planning	Cambodian, Chinese, Korean, Filipino, Samoan, Vietnamese (all with English translation)	2-sided poster with food pyramid, diet/nutrition tips	AAPI Coalition of REACH/ Seattle King County Dept. of Public Health Available from: International Community Health Services 720 8th Ave. S., Suite 100 Seattle, WA 98104 (206) 461-3617, ext. 3111	Download at: http://www.metrokc.gov/health/reach/
Indian Foods: AAPI's Guide to Nutrition, Health and Diabetes	English	86 page book with information on nutrition, food exchange, glossary of Indian foods, including regional differences, different food preparation styles	American Association of Physicians of Indian Origin (AAPI) 17W 300 22 nd Street, Ste. 300A Oakbrook Terrace, IL 60181 (630) 530-2277 www.aapiusa.org	Download at: http://www.aapimsr.org/Diabetes/
Islands Foods are Healthy Foods: Guide for Nutritious Diets	English	103 page spiral bound book on island foods with nutrition information, recipes, other healthy eating tips	ADAP Project University of Hawaii 3050 Mail Way, Gilmore 213 Honolulu, HI 96822 (808) 956-8140 E-mail adap@hawaii.edu	Contact source directly

Information for Providers

Title (in alphabetical order)	Languages Recommended	Material Information	Source/Contact Information	Availability
Chinese American Food Practices, Customs, and Holidays	English	32 page book designed for dietitians: food & health beliefs and practices, holiday food customs, nutrition recommendations and nutritional value info, exchange list, glossary of food terms, modified recipes	Collaboration between: American Diabetes Association American Dietetic Association Contact: The American Dietetic Association 216 W. Jackson Boulevard, Suite 800 Chicago, IL 60606-6995 1-800-877-1600 ext. 500	Purchase at: www.eatright.org
Filipino American Food Practices, Customs, and Holidays	English	32 page book designed for dietitians: food & health beliefs and practices, holiday food customs, nutrition recommendations and nutritional value info, exchange list, glossary of food terms, modified recipes	Collaboration between: American Diabetes Association American Dietetic Association Contact: The American Dietetic Association 216 W. Jackson Boulevard, Suite 800 Chicago, IL 60606-6995 1-800-877-1600 ext. 500	Purchase at: www.eatright.org
Indian & Pakistani Food practices, customs and holidays, 2nd Edition	English	32 page book designed for dietitians: food & health beliefs and practices, holiday food customs, nutrition recommendations and nutritional value info,	Collaboration between: American Diabetes Association American Dietetic Association Contact: The American Dietetic Association 216 W. Jackson Boulevard, Suite 800	Purchase at: www.eatright.org

		exchange list, glossary of food terms, modified recipes	Chicago, IL 60606-6995 1-800-877-1600 ext. 500	
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Hispanic Curriculum

Protect Yourself From Pesticides: A Guide For Pesticide Handlers / Protéjase de los pesticidas: guía para los que manejan pesticidas

Environmental Protection Agency; U.S. Department of Agriculture Extension Service, 1993

Certificate and Worker Protection Branch

Office of Pesticide Programs

Environmental Protection Agency (EPA)

Mail Code 7506C

1200 Pennsylvania Ave., N.W.

Washington, D.C. 20460

PHONE (703) 305-7666

Free

Available in English or Spanish, this 101-page handbook is an official EPA curriculum for training of pesticide handlers. It presents the information which is required by the EPA Worker Protections Standard (WPS). There are 10 units which include information about pesticide exposure, poisoning, first aid, health effects, protective equipment, and the labeling, storing, cleaning, and disposing of pesticides. Each unit has objectives, opening questions, a short passage with factual information, and questions for review and discussion. The type is large, the writing is moderately simple, and there are lots of pictures and white space. At the end, there are suggested responses to the discussion questions in all units, an overview of pesticide regulation, notes for trainers, official information about the WPS protections, and a list of regional EPA offices.

Community Education Program/El Paso Community College

P.O. Box 20500

El Paso, TX 79998

PHONE (915) 831-4176

E-MAIL andresm@epcc.edu

The Education Program at El Paso Community College developed this health curriculum with support from the Pfizer Health Literacy Grants Program. The curriculum focuses on issues relevant to the local community, and uses locally available health education materials. The lesson plans are participatory and include activities for reading, writing, critical thinking, and taking action. It can be used as is or as a model for developing your own curriculum based on your community's needs and resources. Some of the activities involve research on disease rates for different ethnic groups. The handouts and some of the vocabulary are in Spanish and English. Topics include diabetes, breast health, menopause, lead poisoning, and nutrition.

**Excerpt from Curricula
Community Education Program/El Paso Community College**

Menopause Fact Sheet

A. What are the main symptoms and/or conditions of menopause?

- hot flashes
- mood swings
- vaginal dryness
- fatigue
- abnormal uterine bleeding
- depression
- osteoporosis
- weight gain

Some women feel no symptoms or conditions, others feel one or two, and others feel many of them.

B. Hormone Replacement Therapy(HRT)

A common treatment of these symptoms and conditions is called Hormone Replacement Therapy (HRT). This section will look at the benefits and risks of this treatment

Proven Benefits of HRT:

- Relieves hot flashes
- Reduces bone loss
- Relieves vaginal dryness and atrophy

Possible Benefits of HRT:

- Improves cholesterol
- Reduces risk of colon cancer
- Reduces mood swings, mental fogginess, and memory lapses
- Keeps skin and blood vessels more resilient

Proven Risks of HRT:

- Increases incidence of cancer of the endometrium (if HRT does not have progesterone or progestin)
- With progestin, menstrual period can return
- Premenstrual Syndrome (PMS) symptoms

Possible Risks of HRT:

- Higher rate of breast cancer
- Abnormal blood clots
- Weight gain
- Increased risk of gallstones
- Headaches
- Increased growth of benign fibroid cysts in the uterus

10% of women who use HRT also experience:

- Breast tenderness
- Fluid retention
- Swelling
- Mood changes
- Pelvic cramping

Other HRT affects are:

- Nausea
- More yeast infections
- High blood pressure
- Liver disorders
- Blood sugar problems

At nine months, 1/3 of the women who receive HRT stop the treatment because of side effects. At one year, 1/2 of the women who receive HRT stop the treatment because of side effects.

C. Hormone Replacement Therapy and Breast Cancer

Studies have shown that women who use HRT have a higher risk of breast cancer.

- Used HRT for 5-9 years = 59% increased risk for breast cancer
- Used HRT between ages 65-69 = 70% increased risk for breast cancer

D. A good diet can make a difference

These foods are good for everyone, especially women in menopause.

- **Eat soy:** Soy foods like soybeans and tofu contain phytoestrogens. These can help reduce hot flashes, improve moisture and health of vaginal tissue, increase bone mass and reduce cholesterol.

- **Eat fruits, vegetables and legumes:** Many fruits and vegetables contain phytoestrogens and bioflavonoids. Bioflavonoids help the circulatory system, which affects hot flashes, excessive menstruation and varicose veins.
 - ✓ Fruits, vegetables and legumes with phytoestrogen: apples, carrots, garbanzo beans, garlic, green beans and peas.
 - ✓ Fruits with bioflavonoids: citrus fruit, berries, cherries and grapes.
- **Eat whole grains:**
 - ✓ These grains contain phytoestrogens: Oats, barley (cebada) and rye (centeno)
- **Other beneficial supplements:**
 - ✓ Eat flax seeds for a good source of omega-3 essential fatty acids. They also contain phytoestrogen and are good for your heart.
 - ✓ Take Vitamin E orally and also apply to the skin (CAUTION: ask your doctor first if you have high blood pressure or diabetes)

E. Lifestyle Changes

- Do regular exercise – exercise can reduce hot flashes, stress, insomnia and mood swings
- Try to relax – hot flashes, insomnia, anxiety, difficulties in concentration and mood swings are stronger if you feel stress or anxiety
- Positive attitude
 - If you think menopause is terrible, you will feel terrible.
 - If you think menopause is normal and natural, you will feel that it is a normal and natural process.

LAS YERBAS Y LA MONOPAUSIA

Aqui tienen una lista de algunas yerbas que se pueden usar para combatir los efectos molestos de la menopausia.

Lengua de baca (yellow dock) – se usa para combatir la anemia, falta de hierro en la sangre

Diente de leon o amargon (dandelion)- tambien usado para combatir la anemia

Sarasamora (red raspberry) – se usa para ayudar a los musculos que apoyan al utero y los otros organos reproductivos a que esten fuertes y elasticos; demasiado te de sarsamora puede causar insomnio

Gobernadora (chaparral) – se usa para purificar la sangre y el higado; la gobernadora es una planta muy fuerte y si se usa inadecuadamente puede ser venenosa

Zumo de orozuz (licorice) – el jugo de esta planta contiene estrógeno cual le ayudara a tener efectos menos fuertes y tambien ayuda con la digestion

Jengibre (ginger) – Usado para mejorar la circulacion y se dice que puede tomar te de gengibre para que le baje la regla mas rapidamente

Pimienta o pimienta guindilla (cayenne pepper) – estos piemientos se usan para cocinar; se dice que ayudan con la circulacion y ayuda si sufre de manos o piernas frias; esta yerba es muy, muy fuerte

Perejil (parsley) – esta yerba contiene mucho estrógeno y la puede comer o tomar en te; esta es una yerba muy fuerte

Ortiga (nettle) – contiene calico y estrógeno ayuda con todo el sistema reproductivo y puede hasta que ayude a prevenir o retardar el procedimiento de la osteoporosis

Manzanilla (chamomile) – en te, esta yerba ayuda a dormir y relajarse; tambien ayuda con reglas y colicos dolorosos

Salvia (sage) – despues de dar a luz y si ya la mujer no quiere dar pecho, se puede usar el te para parar la produccion de leche maternal

Black cohosh - para bochornos, sequedad vaginal y depresion

AVISO IMPORTANTE: Si uno no sabe usar las yerbas es muy importante que no las use por que algunas formas de las yerbas son venenosa

Multicultural Curriculum

Technical Assistance Bulletins:

Developing Effective Messages and Materials for Hispanic/Latino Audiences

Communicating Appropriately with Asian and Pacific Islander Audiences

Center for Substance Abuse Prevention (CSAP) Communications Team, 1997

Center for Substance Abuse Prevention (CSAP)

7200 Wisconsin Avenue, Suite 500

Bethesda, MD 20814-4820

PHONE (301) 941-8500

Free

These two bulletins are part of a series developed to help substance abuse prevention programs reach their target audiences, but they have enough general information to be helpful for any health education effort. They outline fairly precise strategies for getting a health message across effectively to the specific cultural target populations. Each starts with a review of the demographics of the target culture in the U.S. then outlines the health communication process, discusses how to research the health problem in that culture, how to define the specific target audience, and how to research the cultural issues that will affect the communication with that group. Each bulletin is 12 pages and has useful, concise, and practical information.

Healthy Mothers, Healthy Babies

Healthy Mothers, Healthy Babies Coalition of Washington State, 1995-1999

Healthy Mothers, Healthy Babies Coalition of Washington State

300 Elliott Avenue West, Suite 300

Seattle, WA 98119-4118

PHONE (206) 284-2465 or (800) 322-2588

FAX (206) 270-8891

Cost \$11

These books give simple, clear information on prenatal care, keeping healthy during pregnancy, and early baby care. They are available in English, Spanish, Russian, Somali, Vietnamese, Korean, and Chinese. The Spanish and English versions are 116 pages, and formatted in smaller, spiral-bound books with only the one language. The others, however, are about 40 pages and have English text side-by-side with the other language texts, so that they may be used during an appointment, if necessary, to facilitate a better understanding of the questions patients have. These versions also explain how prenatal care and the labor and delivery process works in the U.S., and include charts which compare the way things are done in the U.S. and in the home country. The writing (in English) is moderately easy-to-read, and there are lots of pictures, white space, and bulleted sections. The print is large, except for the Russian version. The information is comprehensive and includes healthy eating; prenatal visits; a month-by-month guide to healthy activities, body changes, and baby's growth; labor and delivery; breastfeeding; and

immunizations for the baby. The publication dates vary: Spanish, 2000; English, 1999; Russian, 1996; Somali, 1998; Vietnamese, Chinese, and Korean, 1995

Background

Most Americans have their own personal stories about problems in sorting out health issues—from locating a physician in a phone book to making sense of what healthcare professionals tell them. For people who lack basic skills in listening, speaking, and reading in English, such stories become horror stories, resulting in decreased access to and quality of healthcare for themselves and their families, and increased costs to public health agencies (e.g., charity hospitals, public health agencies, Medicare/Medicaid) and employers. As a means of civics education, health literacy is more than a vehicle for developing English skills and a means of learning how to navigate the U.S. health system. In some cases, health literacy can mean the difference between life and death for non-native English speakers. Thus, this project focused on civics education for ESL learners in terms of health literacy and its capacity to increase parental effectiveness. This project was funded through an English literacy and civics education grant from the Louisiana State Department of Education.

Welcome to HELP (Health Education Literacy Program): Teaching Reading and Health Together. You can access all the documents in the HELP Curriculum by clicking the link in the blue box or the link above. Remember, the HELP curriculum was written to be used in conjunction with the book, *What To Do When Your Child Gets Sick*. To order copies of the book, [click here](#). (Volume discounts available.)

To access the HELP curriculum pages, choose the Unit, then click through until you come to the document you wish to view or print out. It's that easy!

Each Unit is organized the same: (Blue/underlined items are folders; black type items are documents)

Sample Unit

Unit 12 Colds and Flu

Unit Index.pdf

1 Vocabulary

Word Bank--Vocabulary by Level.pdf

2 Scenarios

#01 Scenario Level 1.pdf

#02 Scenario Level 2.pdf

#02 Scenario Level 3.pdf

3 Activities

1 Listening (contains Listening exercises; see Writing below)

2 Speaking (contains Speaking exercises; see Writing below)

3 Reading (contains Reading exercises; see Writing below)

4 Writing

#01 Writing Exercise Level 1.pdf

#02 Writing Exercise Level 2-3.pdf

#03 Writing Exercise Level 1-2.pdf

#04 Writing Exercise Level 2-3.pdf

#05 Writing Exercise Level 1-2-3.pdf

5 Thinking (contains Thinking exercises; see Writing above)

Social Marketing Contents

- 1 **Social Marketing and Health Communications**
<http://p2001.health.org/theory/communications.htm>
From the National Clearinghouse for Alcohol and Drug Information (<http://ncadi.samhsa.gov/>)
- 2 **You Can Use Communications Principles To Create Culturally Sensitive and Effective Prevention Materials**
<http://www.health.org/govpubs/MS494/>
From the National Clearinghouse for Alcohol and Drug Information (<http://ncadi.samhsa.gov/>)
- 3 **A Key Step in Developing Prevention Methods Is To Obtain Expert and Gatekeeper Reviews**
<http://www.health.org/govpubs/MS492/>
From the National Clearinghouse for Alcohol and Drug Information (<http://ncadi.samhsa.gov/>)
- 4 **Developing Rural HIV/STD Prevention Education Programs**
<http://www.indiana.edu/~aids/factsheets10.html>
From the Rural Center for AIDS/STD Prevention (<http://www.indiana.edu/~aids/>)
- 5 **The Prevention Marketing Initiative: Applying Prevention Marketing**
<http://www.cdcnpin.org/scripts/display/MatlDisplay.asp?MatlNbr=18458>
From the Centers for Disease Control National Prevention Information Network (<http://www.cdcnpin.org/>)
- 6 **Estimated AIDS Incidence in Racial/Ethnic Minorities, January 1986-December 2001, United States**
<http://www.cdc.gov/hiv/graphics/images/l238/l238.pdf>
From the Centers for Disease Control (<http://www.cdc.gov>)
- 7 **On Social Marketing: A Step-by-Step Guide**
by Nedra Kline Weinreich

Social Marketing And Health Communications

I. Introduction

Social marketing is generally defined as the design and implementation of programs that introduce and promote a social idea or cause. Diffusion of innovations, health communications, and media advocacy are related disciplines with application to ATOD problem prevention. Media campaigns and health message and materials development are integral to the development of comprehensive multilevel, multistrategy approaches and to the dissemination of prevention interventions (National Cancer Institute, 1989; Rogers, 1983). Each of these related topics is briefly reviewed here. The reader is also referred to Section IIIG of the CD-ROM which contains four communication training programs developed specifically for preventionists whose role involves media and public relations.

A. Diffusion of Innovation

Diffusion of innovation is a process outlined by Rogers (1983) by which an innovation (e.g., new idea, approach, strategy) is communicated through certain channels over time among members of a social system. In other words, diffusion is concerned with spreading new ideas. The characteristics of an innovation as perceived by members of a social system determine its rate of adoption.

Certain patterns of adoption, both in time and in the response of receivers of the message, must be considered when initiating an innovation. The social system acts as a kind of collective learning system in which early adopters of an innovation transmit their experiences through interpersonal networks. Opinion leaders play a significant role in the ultimate acceptance of an innovation. Another crucial factor is readiness for change (e.g., the readiness of individuals, groups, and/or systems). Schinke and Orlandi (1991) describe work of various researchers on innovation and change and their diffusion. Five phases of programmatic implementation for social and health education efforts are outlined: mobilization, adoption, implementation, maintenance, and evolution. This work builds on the work of Rogers (1983) and is intimately related to the transfer of learning and technology.

B. Health Communications

Communications campaigns work better when expectations are more realistic for their outcomes, when useful strategies are borrowed from social learning and social marketing, and when entertainment strategies from mass communications have been incorporated (Backer and Rogers, 1992). As we seek to alter human behavior, for example, by trying to promote smoking cessation or drug abuse prevention, we are using a communication process that relies upon social systems and their functioning. Customs, norms, values, and leadership patterns must be considered in formulating social change strategies targeted on society as a whole or on a single community.

Furthermore, a single marketing message limits potential response. When planning educational campaigns as part of a comprehensive prevention intervention, it is essential to understand the audience and to test the message being used. Messages of antidrug campaigns of the past have tended to focus on negative consequences of drug behavior to deter use. As we move from an individual behavior-change focus to a multilevel, multistrategy approach to prevention, the full

range of human needs should be taken into consideration to enlarge the possibility of reaching the intended audience with an appropriate and effective message (McGuire, 1991).

In addition, further research is needed to assess the importance of the messenger. A study of the use of lay health educators to promote smoking cessation in a hard-to-reach urban community (Lacey et al., 1991) raised an often overlooked question in prevention practice: does the messenger matter as much as the message? Research in health communications is exploring this and other issues.

William McGuire (1991) lists the following steps individuals must go through to assimilate a desired behavior:

- Exposure to the message
- Attention to the message
- Interest in or personal relevance of the message
- Understanding of the message
- Personalizing the behavior to fit one's life
- Accepting the change
- Remembering the message and continuing to agree with it
- Being able to think of it
- Making decisions based on bringing the message to mind
- Behaving as decided
- Receiving positive reinforcement for the behavior
- Accepting the behavior into one's life.

The PRECEDE Module, developed by Green and Kreuter (1991), suggests that individuals need to be considered in the context of their community and society as a whole when social marketing strategies are developed. Individuals are influenced by

- Predisposing factors—knowledge, attitudes, behavior, beliefs, and values prior to intervention that affect their willingness to change
- Enabling factors—the structure of the environment or community and the individual's situation that facilitate or present obstacles to change
- Reinforcing factors—the positive or negative effects of adopting the behavior that influences continuing the behavior.

C. Media Advocacy

Media advocacy involves understanding and working with the news media to turn public attention to an issue and pressure policy makers to act. Furthermore, media advocates craft a story to focus on specific solutions involving change through policy development. They focus on the news media as a far-reaching channel of communication (Berkeley Media Studies Group, 1994).

Whereas social marketing tries to influence individual behavior change, media advocacy aims to improve health by influencing the social and political environment in which decisions are made.

Wallack (1990) states the following:

...media advocacy reflects a progressive approach to health promotion in that it explicitly recognizes the importance of the environment and defines health problems as matters of public policy and not just of individual behavior. It tries to empower individuals by providing the knowledge and skills necessary for participation in efforts to change the social and political factors that influence health status. The health of the community, not necessarily that of the individual, is the main concern.

II. How Social Marketing Works

Social marketing uses commercial marketing tools to “sell” products and ideas for the public good. The key to a successful social marketing campaign is learning what will work with the target population. This is far more effective than simply telling people what they “should do.” The target population is more likely to adopt a desired behavior if we assess and subsequently try to change their attitudes toward the behavior, their perceptions of benefits of the new behavior, and their perceptions of how they think their peers will view their behavior. In the substance abuse prevention arena,

A. The Four “P’s” of Social Marketing

With each social marketing program, the concept of a target population is constant. The variables are the product being promoted, the price, the promotion, and the place or channel whereby the information reaches the consumer.

- **Product** is the knowledge, attitudes, or behavior you want the target audience to adopt. The product can be an idea such as not using alcohol, tobacco, or other drugs. The product could also be an actual related commodity such as seeds for a substitute cash crop such as wheat or corn, or a nicotine substitute to help smokers quit.
- **Price** is what audience members must give up to receive the program’s benefits. This price is usually something more abstract than money. It might be the psychological cost of separating oneself from friends or the peer group that continues to use drugs, or the psychological and physical trauma of fighting an addiction.
- **Place**, or the channel, refers to how the message is disseminated. Channels could include mass media, schools, churches, or workplaces. Keep in mind that place affects price. For instance, if the message is promoted by an organized youth group, the price of peer pressure may be reduced. Choose the channel which is most appropriate for the target audience.
- **Promotion** is the means for persuading the target audience that the product is worth this price. It may include a publicity campaign through the mass media but it can also involve teaching life skills or community activities. (Bureau of International Narcotics Matters, 1988)

B. Eight Specific Components In the Social Marketing Process

Lefebure and Flora (1988) suggest that there are eight components in the social marketing process. They are

- Consumer orientation
- Voluntary exchange

- Audience analysis and segmentation
- Formative research
- Channel analysis
- Marketing mix
- Process tracking
- Management

The Center for Substance Abuse Prevention has taken these concepts and outlined a detailed process for developing prevention programs, using social marketing principles.

C. CSAP's Eight Guidelines for Social Marketing Program Development

The Center for Substance Abuse recommends that prevention programs follow specific guidelines during the development of a social marketing program.

- | | |
|---|---|
| ■ | Guideline 1. Follow a six-stage social marketing process. |
| ■ | Guideline 2. Understand what communications can do. |
| ■ | Guideline 3. Use a public-health approach to prevention. |
| ■ | Guideline 4. Reflect and respond to cultural diversity. |
| ■ | Guideline 5. Involve the audience at all stages. |
| ■ | Guideline 6. Explore innovative strategies. |
| ■ | Guideline 7. Use multiple channels. |
| ■ | Guideline 8. Learn from successful programs. |

Guideline 1: Follow a Six-Stage Social Marketing Process that provides multiple opportunities for improvement and refinement.

The six stages include

- Stage One:** Plan your approach
Stage Two: Define your messages and channels.
Stage Three: Develop and pretest your materials.
Stage Four: Implement the program.
Stage Five: Evaluate the program.
Stage Six: Use feedback to refine the program.
-

Stage One: Plan your approach

1. Research the scope of the problem.
2. Review the research literature.
3. Define your audience.
4. Develop your concept.
5. Set goals and objectives.

Before the concept of substance abuse prevention can be marketed to a community, it's important to understand the community. An analysis of the community will help to identify its driving (positive) and restraining (negative) forces. An action plan with specific goals and objectives can be developed which builds on the driving forces, diminishes the restraining forces, and strengthens the community's prevention efforts. Even small, apparently homogeneous communities have various subgroups within their populations. Categories such as age, sex, ethnicity and cultural background, socioeconomic groups, literacy or educational level, occupation, or gang membership can be used to define subgroups. An audience may consist of one of these subgroups (for example, adolescent males) or a combination of groups (adolescent males, and their parents).

A social marketing program may need to address more than one audience to accomplish its objectives. Planners often differentiate among primary, secondary, and tertiary audiences:

- Primary audience—the group of people that the program is designed to influence, for example, young adolescent males.
 - Secondary audience—those individuals who influence the primary audience, for example, the peers, parents, teachers, and employers of young adolescent males.
 - Tertiary audience—the decisionmakers, the community's gatekeepers. These are the individuals who influence policy and offer financial and logistical support to community-based prevention programs. The support of this group is critical to any prevention program. In some social marketing programs, these individuals may be the primary audience.
-

Stage Two: Define your messages and channels.

1. Identify the message(s) you want to send.
2. Choose appropriate and effective channels of communications.

Identify the message(s) you want to send.

What message will work? The message has to be meaningful and appealing to the target audience. If the message is that substance abuse is directly linked to violent crime, give an example appropriate for the target audience. For instance, car hijackings might be more appropriate for an urban than a rural audience. The message should get your audience to think about and discuss the issues. Try to generate action. Convey clear, concrete suggestions. For example, show alternative behavior or ways of resisting pressure to use drugs. The message should be based on facts and tied to the present, not the distant future. Our society has a tendency to live primarily in the here and now with an emphasis on instant gratification. The outcome of "cirrhosis of the liver in 20 years" poses little threat to an 18-year-old. CSAP cautions that messages that may do more harm than good—e.g., "scare tactics"—should be avoided. The program's or campaign's ultimate outcome should be to establish social norms that promote and sustain healthy, safe behaviors. Change does happen—it just may take a while. Product positioning refers to the niche that a product occupies in people's minds. In commercial marketing, this niche is created by packaging and promotion. In social marketing, the niche is the cultural and psychological appeal of a product. For instance, it's okay not to belong to a gang, or community service can help put your problems in perspective, or running and other vigorous exercise produce a natural high. The message should highlight this appeal.

What is the cost? The message should minimize the psychological or physical cost of the product. For example, if an adolescent thinks that giving up drugs will cost him or her status among peers, the message might minimize this cost by emphasizing well-known male and female athletes, musicians, or movie stars who don't use illegal drugs or abuse alcohol.

Choose effective channels of communications.

These include television, radio, newspapers and other print media, and bulletin boards throughout the community such as those found in supermarkets, churches, neighborhood centers, and other places where people congregate. According to the Bureau of International Narcotics Matters (1988), the following factors should be considered in choosing a channel or channels:

- **Reach**—The number of people or households exposed to a specific media message during a specific period of time. These data may be available from previous studies or the target population can be surveyed to see what stations or shows they prefer, what newspapers or magazines they read, and what their literacy/educational levels are.
- **Frequency**—The average number of times an audience is exposed to a specific message. Remember that repetition helps to convey a message.
- **Impact**—What effect will the use of each channel have on the target audience? Keep in mind the characteristics of each type of media. For example, television and radio have mass appeal but are costly, so messages will probably be short. Print media can give instructions or more detailed information.
- **Credibility**—How credible do members of the target audience find the channel? Some people find television believable while others find newspaper articles more convincing.
- **Cost effectiveness**—Is the cost offset by the benefits? For example, during the 1996 Olympics, advertisers paid approximately \$500,000 for a 30-second spot during prime time and reached an estimated 21 to 22 million viewers.

Stage Three: Develop and pretest your materials.

1. Develop message statements and concepts.
2. Test materials with target audience(s) and important community gatekeepers.
 - Determine whether the target audience responds to the product(s) and the message is clear.
 - Revise the product(s) based on pretests.

One key to the development of successful public education materials is to ensure that there is a continuous flow of information between the target audience and the developers of the materials. This is one reason why testing materials before they are released to the general public is so critical. If the materials are inappropriate or unappealing to the test audience, using them would be a disaster.

Apply the message statement.

The message statement outlines information critical to the development of accurate materials that are successfully received by the target audience. It keeps the development of the materials on target. Further, the message statement provides a common knowledge base for everyone involved, and can be used in presentations which need to be made in advance of the campaign.

The message statement includes

- Statement of the problem
- Goals of the campaign or other social marketing activity
- Definition of the target audience
- What has been learned about the target audience's needs, values, and perceptions
- Channels to be used
- The idea/message to be communicated.

Develop the message concepts.

Message concepts are the preliminary ideas which eventually become draft materials after they are tested and refined. Message concepts are verbal descriptions that convey the basic form and appeal of the message including its presentation style, the spokesperson or source, and the slogan or other essential words or symbols.

Keep in mind as you develop your program's message that we live in a society bombarded on all fronts by diverse messages. Your message must compete with many others for attention. Appeal, style, personal relevance, and the spokesperson or source of information will influence how well a message attracts and holds the target audience's attention.

Appeal to reason and emotion.

A message can appeal to a variety of emotions and perceptions such as logic and reason, self-esteem, fear, and patriotism. Design the message to appeal to a variety of emotions and perceptions. Keep in mind that a moderate amount of emotional appeal works better than none,

especially with people who are indifferent to a problem to begin with. "Scare tactics" are not as effective as appeals to more positive emotions. However, fear of social disapproval may be an exception. Appeals to fear have been most effective when anxiety can easily be reduced. If the message explains how to reduce the fear, it will give a sense of control back to the audience. Appeals to fear are more likely to work when the person hearing the message does not feel vulnerable. Ironically, the most vulnerable people appear least likely to respond to appeals to fear. Appeals to fear are more successful when delivered by a highly credible source.

A factual approach is most successful with people who are already highly motivated. A sophisticated audience of opinion leaders is more likely to respond to this sort of appeal. Humor works best when the message has become familiar. Keep in mind that people, even within the same target audience, have very different senses of humor and some humor can offend (Bureau of International Narcotics Matters, 1988).

Use an engaging style.

Broadcast messages can employ various techniques, e.g., a spokesperson's testimonial about a personal experience; the portrayal of a common, everyday situation; a demonstration of a skill such as saying no to a drug dealer; or a series of vignettes portraying situations with a common theme. Printed materials can be primarily visual with little text or primarily text. Printed materials frequently use cartoons, charts, photographs, and graphics to present the message. Common formats for printed brochures and factsheets include questions and answers, newsletter format, or report format. Be sure that the format used is appropriate for the age, educational, and literacy levels of the audience. For example, second graders would probably respond more favorably than eighth graders to a coloring book.

Vocabulary, tone, and appeal should make the target audience feel that this message is meant for them.

Consider the spokesperson or source. The choice of spokesperson should reflect the interests of the target audience and be seen by the audience as credible. A basketball star may appeal to adolescents but their parents may react more favorably to a well-known medical personality.

Test message

If funding is available, professionals can be hired to complete the pretesting evaluation process. Alternatives include using faculty and staff of a local university or college or using community volunteers. Materials should also be reviewed by community gatekeepers including program funders and key people in the community's prevention program.

Pretesting assesses the audience's response to the campaign. It measures recall, comprehension, reaction—Is the message believable? It is relevant? Acceptable? What are the strong points? The weak points?

Pretesting methods include:

- **Focus groups**—Small groups of 8 to 12 people who meet with a moderator to discuss ideas and materials. Focus groups are especially helpful in the early stages of materials development to test themes, images, and general issues.
- **Interviews**—In-depth interviews can be used to gauge an individual's reactions to a sensitive issue and/or specific materials.

- **Central-location-intercept interviews**—These interviews are held in public areas where members of the target population congregate. These areas include shopping malls, movie theaters, schools, and churches. Questions are designed for quick answers that are easily tabulated.
- **Theater testing**—Many people in the same location view messages (such as public service announcements) embedded in other programming.
- **Self-administered questionnaires**—(mailed or delivered) This method provides access to people in rural areas or those who are not likely to attend focus groups or to be in areas for central-location- intercept interviews.
- **Readability testing**—Used to gauge the reading levels of materials. One widely used formula uses both sentence length and syllable counts to estimate reading levels.

Stage Four: Implement the program.

1. Promote and distribute through all channels chosen.
2. Review activities and track audience reactions.
3. Review as necessary.

A method for tracking and evaluating the program should be in place before kickoff. This tracking method will identify areas of success and areas where improvement is needed. The most successful programs are always being updated with current information about the target audience and the program itself.

Evaluate the effectiveness of your media materials. Monitor which pieces were published/broadcast and which were not selected. How many times were public service announcements (PSAs) aired? Inventory the materials on hand. Did the press release get published, but not the op-eds or letters? The problem may simply be column space: newspapers can publish event information throughout the paper, whereas guest editorial space may be very limited or reserved weeks in advance. Mail materials well in advance of when you want the information to be published.

Controversy can inhibit publication, especially in smaller communities. Present your prevention information in terms that evoke sympathy and agreement. Use positive language. Avoid sarcasm and blame.

Look for communications problems within the pieces that did not get printed or broadcast. Stick to one subject and don't ramble. Present a single issue, back it up with facts, and state the results you would like to achieve. The more focused you are, the more effectively your message comes across.

Stage Five: Evaluate the program.

1. Determine what has worked well based on the goals and objectives established at the beginning of your program.
2. Assess how the program affected the beliefs, attitudes, and behaviors of the target population.

Evaluation is an ongoing process that enables prevention planners to discover strengths and weaknesses and to refine the product. It provides hard data used to determine cost effectiveness. Concrete achievements can be cited to solicit additional funding and to promote community support for substance abuse prevention efforts.

Four types of evaluation are generally used in health communications:

- Formative evaluation includes pretesting of materials and is designed to test for program strengths and weaknesses before implementation. It is used in stages one through three.
- Process evaluation reviews the tasks of implementing the program. It tracks program activities. It answers questions such as What did we do well? What do we need to improve? How do we improve?
- Outcome evaluation describes the program's immediate effects. It answers such questions as, Did the target population show any measurable changes in behavior, attitude, knowledge, or perception? Did their awareness of alcohol and other drug problems increase?
- Impact evaluation focuses on the long-term outcomes of the program. It answers such questions as, What effect has the program had on the community? How have the beliefs and behaviors of the target populations been influenced? What changes have occurred in how community members think about the use of alcohol, tobacco, and other drugs?

Note: The design, development, and analysis of both outcome and impact evaluations require the skills of a trained professional.

Stage Six: Use Feedback to refine the program

1. Revise the community's prevention program to maximize its effectiveness.
2. Receive feedback.

Talk to community members. Ask them how the campaign changed what they believe about substance abuse. Ask them what they thought was effective. Ask what didn't work and what suggestions they have for improvement. Use the same techniques as in pretesting.

Provide feedback.

Most people respond well to positive feedback. And many of us like to be thanked when we've made an effort to follow through with a request. Be sure to thank

- Members of the program's media and/or campaign committee(s)
- Funders and other sponsors
- Community members who helped with the campaign
- Campaign spokespersons
- Members of the media who participated in and/or supported the campaign.

Effective communications are integral to the prevention of alcohol, tobacco, and other drug problems. They provide information, mobilize public support for prevention, and enhance other prevention strategies. —Elaine Johnson, Ph.D., Director, Center for Substance Abuse Prevention

Guideline 2: Understand what social marketing and communications can do.

A strong community-based prevention program includes activities that support the six prevention strategies and comprehensive communication efforts. The program will target a specific audience with a prevention message and increase the general public's awareness of prevention-related issues. Raising of public awareness ultimately results in a change in social policies and practices.

Effective social marketing/communications can

- Raise awareness
- Increase knowledge
- Influence attitudes
- Show benefits of behavior change
- Reinforce knowledge, attitudes, and behavior
- Demonstrate skills
- Prompt an immediate action
- Increase demand for services
- Refute myths and misconceptions
- Influence norms
- Raise the volume of the public health voice.

Guideline 3: Use a public health approach to prevention.

The public health model stresses that problems arise through the interaction of a host(s), agent, and environment. Prevention programs that focus totally on the host may overlook the influences in the environment or community that promote substance abuse. Effective programs take a comprehensive approach. They look not only at individual risk and resiliency factors, but also at community norms, local laws such as those relating to drinking age, availability of alcohol, and other factors.

Guideline 4: Reflect and respond to cultural diversity.

Cultural changes are constant in all societies, especially today with the ease of travel and the high rate of immigration. Some people rush to accept new ideas, technologies, and values. Others, in the face of rapid change, turn to traditional values for support. Understanding how people respond to change is a critical component to understand when designing educational messages. Other issues to be addressed include assimilation, immigration, and discrimination issues.

In minority communities, successful prevention programs also deal with the dynamics of drug use specific to their differing cultures. These programs promote cultural understanding and pride in a shared heritage while confronting whatever problems of alcoholism or other drug abuse are most common to their particular community (Office of National Drug Control Policy, 1993). (See also Section I E, Cultural Diversity.)

Guideline 5: Involve the audience at all stages.

- Use focus groups and theater testing to learn about needs and preferences.
- Involve members of the target audience in the preparation of materials. This involvement not only helps to ensure that materials will be appropriate for the target audience, but helps to create ownership. At the same time, these individuals are acquiring knowledge, new skills, and self-esteem.

Guideline 6: Explore innovative strategies.

These include

- Developing online computer databases
- Helping communities plan live, call-in supplements to nationwide television
- Using computer-generated animation in combination with live action
- Using computer-generated art and desktop publishing to create inexpensive professional posters, flyers, and other printed materials
- Music videos.

Guideline 7: Use multiple channels and methods.

This ensures more coverage of the issues as well as better chances of reaching the target population. Channels and methods include posters, radio spots, brochures, satellite networking, small groups, take-home projects, music and visual arts programs. A multiple-outlet or a limited-outlet approach may be used.

- Multiple outlet—a total social marketing program that uses as many available resources as possible including television and radio stations, newspapers, and billboards. The community is inundated with information from these multiple outlets.
- Limited outlet—a concentrated effort by one or two outlets. Each makes a more significant commitment of time and resources than in a multiple outlet effort. The benefit to these two outlets is that the campaign becomes closely tied and related to each.

Guideline 8: Learn from successful programs.

Don't reinvent the wheel. Many communities have been through the process you are now beginning, and a little research can get you information on why they started their program, what they did, what worked, and what didn't. A number of information sources are listed below.

Campaign for Tobacco-Free Kids
515 North State Street
Chicago, IL 606120
1/800/284-KIDS

Center for Alcohol Advertising
2140 Shattuck Avenue, Suite 1206
Berkeley, CA 94704

<http://p2001.health.org/THEORY/communications.htm>

Center for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
404/639-3824
<http://www.cdc.gov/cdc.htm>

Center for Media Literacy
4727 Wilshire Boulevard, Suite 403
Los Angeles, CA 90010
213/931-4177
1/800/226-9494
<http://websites.earthlink.net/~cml>

CSAP's National Clearinghouse of Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
1/800/729-6686
TDD Number: 1/800/729-6686
Web site: <http://www.health.org>
E-mail address: webmaster@health.org

Indiana Prevention Resource Center
<http://www.drugs.indiana.edu>

Partnership for a Drug-Free America
(Develops Public Service Announcements)
405 Lexington Avenue, 16th Floor
New York, NY 10174-0002
212/922-1560

Policy and Media Center on Alcohol and Other Drug Issues
Institute for Health Advocacy
1717 Kettner Boulevard, Suite 200
San Diego, CA 92101
619/238-9210

The Web of Addictions
<http://www.well.com/user/woa>

Join Together
(Publishes monthly media action kits)
441 Stuart Street, 6th Floor
Boston, MA 02116
617/437-1500
Website: <http://www.jointogether.org/>

National Institute of Health
<gopher://gopher.nih.gov>
National Institute on Drug Abuse/NIH
5600 Fishers Lane
10A-54 Parklawn Building
Rockville, MD 20857
1/800/662-HELP

National Association of State Alcohol and Drug Abuse Directors
Arts and Sciences Outreach Office
University of Wisconsin-Eau Claire
Eau Claire, WI 54702-4004
715/836-2031

Office of National Drug Control Policy
[gopher://ncjrs.aspensys.com:71/11/drugs](http://ncjrs.aspensys.com:71/11/drugs)

III. Summary

Social marketing uses commercial marketing tools to "sell" products and ideas for the public good. The key to a successful social marketing campaign is learning what will work with the target population.

In terms of substance abuse prevention

- Product is the knowledge, attitudes, or behavior you want the target audience to adopt.
- Price is what audience members must give up to receive the program's benefits.
- Place, or the channel, refers to how the message is disseminated.
- Promotion is the means for persuading the target audience that the product is worth this price.

The Center for Substance Abuse Prevention recommends that prevention programs follow the following eight guidelines for communication program development:

Follow the Six-Stage Health Communication Process

1. Understand what communications can do
2. Use a public health approach to prevention
3. Reflect and respond to cultural diversity
4. Involve the audience at all stages
5. Explore innovative strategies
6. Use multiple channels
7. Learn from successful programs

Bibliography

Alcalay, R., A. Ghee, and S. Scrimshaw. 1993. Designing prenatal care messages for low-income Mexican women. Public Health Reports 108(3):354-362.

Backer, T., E. Rogers, and P. Sopory. 1992. Designing Health Communication Campaigns. What Works? Newbury Park, CA: Sage Publications.

Backer, T., and E. Rogers, eds. 1993. Organizational Aspects of Health Communication Campaigns. What Works? Newbury Park, CA: Sage Publications.

Berkeley Studio Media Group. 1994. Definition of media advocacy. Berkeley, CA: Berkeley Studies Media Group.

Bochner, S. The effectiveness of same-sex versus opposite-sex role models in advertisements to reduce alcohol consumption in teenagers. Addictive Behaviors 19(1): 69-82.

Bureau of International Narcotics Matters. 1988. Building public awareness: Handbook for drug awareness campaigns. Prepared by Macro International, Inc. Washington, DC: U.S. Department of State.

Casswell, S., L. Gimore, V. Maguire, and R. Ransom. 1989. Changes in public support for alcohol policies following a community-based campaign. British Journal of Addiction 84:515-522.

Cohen, A., M. Colligan, and P. Berger. 1985. Psychology in health risk messages for workers. Journal of Occupational Medicine 27(8):543-551.

Convissor, R., R. Vollinger, and P. Wilbur. 1990. Using national news events to stimulate local awareness of public policy issues. Public Health Reports 105(3):257-260.

DeFoe, J., and W. Breed. 1988. Youth and alcohol in television stories, with suggestions to the industry for alternative portrayals. Adolescence XXIII(91)(4):533-550.

Gellert, G., K. Higgins, W. Farley, and R. Lowery. 1994. Public health and the media in California: A survey of local health officers. Public Health Reports 109(2):284-289.

Glassman, A.M. Rethinking organization stability as a determinant for innovation option/diffusion. Tarzana, CA: California State University.

Green, L. and M. Kreuter. 1991. Health promotion planning: An educational and environmental approach. 2nd ed. Mountain View, CA: Mayfield Publishing Co.

Job, R. 1988. Effective and ineffective use of fear in health promotion campaigns. American Journal of Public Health 78(2):163-167.

Johnson, E., and J. Delgado. 1989. Reaching Hispanics with messages to prevent alcohol and other drug abuse. Public Health Reports 104(6):588-594.

Koplan, J., and F. Gutzwiller. Some observations on the assessment of preventive technologies. International Journal of Technology Assessment in Health Care 7(3):361-364.

Lacey, L., S. Tukes, C. Manfredi, and R. Warnecke. 1991. Use of lay health educators for smoking cessation in a hard-to-reach urban community. Journal of Community Health 16(5):269-282.

Lefebure, R.C., and J.A. Flora. 1988. Social marketing and public health intervention. Health Education Quarterly 15:299-315.

Linney, J. 1990. Community psychology into the 1990s: Capitalizing opportunity and promoting innovation. American Journal of Community Psychology 18(1):1-17.

McGuire, W. 1991. Using guiding-idea theories of the person to develop educational campaigns against drug abuse and other health-threatening behavior. Health Education Research 6(2):173-184.

McGuire, W. 1995. Transferring research findings on persuasion to improve drug-abuse prevention programs. In *Reviewing the behavioral science knowledge base on technology transfer*, eds. T. E. Backer, S. L. David, and G. Soucy. NIDA Research Monograph 155. Rockville, MD: National Institute on Drug Abuse.

McKinney, M., J. Barnsley, and A. Kaluzny. 1992. Organizing for cancer control: The diffusion of a dynamic innovation in a community cancer network. International Journal of Technology Assessment in Health Care 8(2):268-288.

National Cancer Institute. 1989. Making health communications work: A planner's guide. Rockville, MD: U.S. Department of Health and Human Services.

Office of National Drug Control Policy. 1993. Substance Abuse Prevention: What Works and Why? Washington, DC: Executive Office of the President.

Orlandi, M., L. Lieberman, and S. Schinke. 1988. The effects of alcohol and tobacco advertising on adolescents. Drugs & Society 3(1-2):77-97.

Pittman, D.J., P. Anderson, and L. Wallack. 1993. Commentaries. Further comments on Warning: The alcohol industry is not our friend? (with Wallack's reply). Addiction 88:167-178.

Rogers, E. Communication campaigns to change health-related lifestyles. Supplement Hygiene 11:29-35.

Rogers, E. 1983. Diffusion of Innovations. 3rd ed. New York: The Free Press.

Rohrbach, L., J. Graham, and W. Hansen. 1993. Diffusion of a school-based substance abuse prevention program: Predictors of program implementation. Preventive Medicine 22:237-260.

Roper, W. 1993. Health communication takes on new dimensions at CDC. Public Health Reports 108(2):179-183.

Rowley, B. 1990. A case for social marketing and education for acceptance and implementation of preventive health and occupational safety measure programs for rural communities. American Journal of Industrial Medicine 18:443-447.

Scheirer, M. 1990. The life cycle of an innovation: Adoption versus discontinuation of the fluoride mouth rinse program in schools. Journal of Health and Social Behavior 31(6):203-215.

Schinke, S., and M. Orlandi. 1991. Technology Transfer. In *Drug abuse prevention intervention research: Methodological issues*, eds. C. Leukfeld and W. Bukoski. NIDA Research Monograph 107. Rockville, MD: National Institute on Drug Abuse. (DHHS Publication No. ADM 91-1761.)

Sorenson, J., and W. Clark. 1995. A field-based dissemination component in a drug abuse research center. In *Reviewing the behavioral science knowledge base on technology transfer*, eds. T. E. Backer, S. L. David, and G. Soucy. NIDA Research Monograph 155. Rockville, MD: National Institute on Drug Abuse.

Visser, L., and M. Botha. 1991. Alcohol on the television and in viewers' experience. Medicine and Law 10: 95-105.

Wallack, L. 1990. Two approaches to health promotion in the mass media. World Health Forum 11:143-164.

<http://p2001.health.org/THEORY/communications.htm>

Wallack, L. 1992. Warning: The alcohol industry is not your friend? Editorial. British Journal of Addiction 87:1109-1111.

Wallack, L. 1993. Media advocacy: A strategy for empowering people and communities. A paper presented at the University of California School of Public Health 50th Anniversary Symposium: Shaping the Future of Public Health: Perspectives from Berkeley, April.

Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

PreventionWORKS!

Technical Assistance Bulletin

You Can Use Communications Principles To Create Culturally Sensitive and Effective Prevention Materials

September 1994

Prevention messages and materials can contribute to improving the health status of the Nation's racial and ethnic communities. However, to develop viable messages for target audiences, you should understand:

- Principles of health communications
- The culture of the audience that you are trying to reach.

Customizing messages and materials can make your outreach more effective with special populations.

Culture affects how people respond to messages communicated through various channels: mass media, community events, family discussions, and person-to-person encounters. Culture is also intertwined in how alcohol, tobacco, and other drugs are used in various communities.

This bulletin will help you identify some ways to incorporate cultural sensitivity and effectiveness into your communication projects.

Methods of targeting groups for messages and materials are viewed on two dimensions:

- Primary-based on culture and linked to race, ethnicity, language, nationality, and religion
- Secondary-based on additional elements such as age, gender, sexual preference, educational level, occupation, and income.

Experience has shown that there is no magic formula that works for all African Americans, all Asian Americans, all Hispanics, all American Indians. What is clear, however, is that simply substituting multicultural faces for White faces in messages and materials is not effective. Considerable work must be done to create an information flow that is viewed and accepted as part of the culture.

The Role of Culture

Culture is important to all of us. As Americans, we all share elements of a "national" culture -- things like basketball, hot dogs, high school bands playing Sousa marches, and the Fourth of July.

But many Americans also carry the gifts and strengths of other cultural traditions. We are African Americans, Asian Americans, European Americans, American Indians, Hispanics, Creoles, Cajuns, and mixtures of many races and ethnicities. We play soccer, eat tacos, listen to reggae, dance at powwows, and join the parade on the Chinese New Year. Our cultural backgrounds and heritages affect the way we dress, the food we eat, the music we listen to, the festivals we celebrate, and much more.

One of the difficulties in the United States today is defining culture. All too often, culture is seen as identical to race, ethnicity, language, nationality, or religion. While culture draws on all these elements, it is not synonymous with any of them.

Culture incorporates the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a people. Culture shapes how people see their world and structure their community and family life. Culture defines what people value and hold dear.

The primacy of one culture does not mean other cultures cease to exist. It does mean, however, that many of the messages and materials tend to use the images, symbols, and language of the primary culture and not of the other cultures within the Nation.

Of course, some definitions of culture are broader than this. Groups like youth or veterans do share values, traditions, and institutions. However, while treating such groups as distinctive cultures may be useful for some interventions, it is not generally as effective in the development and implementation of communication strategies. This is because the shared values and history that people have based on these linkages tend not to be as powerful as the shared values and history that come from the more classical definition of culture which encompasses social interaction passed down through generations.

Nationality

Culture often corresponds with nationality. However, people living within the same nation may have very different cultures, and people living in neighboring nations may actually share the same culture.

In a nation like the United States, where many groups of different ancestry have come together as citizens, one culture usually becomes the primary culture of the nation. That unifying culture is then modified by the contributions of many other cultures. In this Nation, the primary American culture is English speaking with its roots in Western Europe and Protestant religion. However, this does not mean that American culture is simply transplanted European culture.

While the national culture of the United States has its roots in Western Europe, there have been changes over time, making the national culture more inclusive of non-Europeans. Indeed, much that is distinctive in the culture of this Nation is due to gifts of other cultures that have been incorporated into the national culture. This is true for music, food, styles, of dress, holidays, poetry and other forms of American literature, and the visual arts.

Language

Language often acts as a conveyer of cultural values. However, having the same language does not automatically mean that people share the same culture. For example, Spanish-speaking persons in the Americas represent three distinctive cultures:

- European (Hispanics with ancestry from Spain)
- African (many Hispanics from the Caribbean and parts of Central and South America)

- Indian (Hispanics whose ancestors lived in the Americas before the arrival of Columbus).

Similarly, among French-speaking individuals, the cultures of French Canadians, Haitians, and immigrants from France are quite distinctive.

Use of messages and materials in languages other than English can be valuable, but they should be developed and tested with particular care. Often the well-educated leadership of a target audience may prefer English while the majority of the audience may be more receptive to another language. In such cases, you may decide to use a bilingual approach that satisfies the gatekeepers while ensuring that the messages and materials reach their intended audiences.

Sometimes you may need to translate from standard English to whatever hybrid form of the language best reflects the special history and culture of your target populations. This does not mean a heavy-handed use of dialect, slang phrases, and poor grammar. Rather it requires the appropriate use of phrases and word images that have special meaning to target audiences but which may not be noticed at all by others who are not part of the culture. This approach must be pretested carefully with the target audience. It is easy to cross the line and create messages and materials that target the community in a manner that is insensitive, insulting, or unintentionally humorous.

Translations should be handled by professionals who understand the nuances and context of language as well as the formal structure.

Frequently the essence of a culture is expressed through its proverbs and traditional sayings. A saying from Africa is that "it takes a village to raise a child." This expresses community support for persons outside the nuclear family becoming directly involved with disciplining and directing a child. A saying from Asia is that "the nail that stands up gets hammered down." This speaks to community disapproval of individual displays of wealth or achievement and emphasis on community progress. In many communities, therefore, it is important for prevention campaigns to place high priority on the value of community.

A word-for-word translation often misses key elements of the intended message and communicates wrong or confusing information. Fluency in a language other than English (particularly if the language was learned in a classroom setting) does not always provide the insight into the culture necessary for an effective translation.

Cultural Values and Attitudes

When designing targeted prevention messages for various cultures, you may encounter beliefs about alcohol, tobacco, and other drugs that are part of their cultural framework. All cultures have beliefs about health based on folk wisdom, tradition, and custom. These may be old patterns that no longer work or new ways of coping with American culture. When these beliefs run counter to current research and scientific information, or if they conflict with established or changing norms of the national culture, this can present special challenges.

Prevention messages and materials should be both culturally sensitive and effective with the target population. Using culturally sensitive symbols and language is not enough if the materials do not communicate clear information to the audience.

For example, some cultures believe that it is masculine for men to drink and smoke but place sanctions on women for the same behavior. In other cultures, use of alcohol by teenagers may be viewed as a relatively harmless rite of passage and not as an illegal and sometimes dangerous practice. Folk "wisdom" -- such as stories about the so-called amazing curative powers of alcohol or mind-altering drugs for various ailments -- many run counter to scientific facts. New information, like the dangers of using alcohol and cocaine during pregnancy, may be greeted with suspicion.

Culture is interrelated with many of our attitudes and values. These include:

- Whether primary importance is placed on the individual or on the community.
- Generally accepted roles for women, men, and children
- Whether the preferred family structure is nuclear or extended, one generation or multigenerational
- Relative importance of folk wisdom, life experience, "mother wit," and common sense in comparison to formal education and advanced degrees.
- Ways that wealth is measured -- in material goods, like money and property, or in personal relationship, like children, extended family support systems, and friendships
- Whether the society reveres its youth as the promise of the future or its elders as the repositories of wisdom
- How time is used and valued, for example, importance of timeliness
- Whether people are tradition bound or open to experimentation
- Linkage or separation between religious life and/or spirituality and secular life
- Favorite and forbidden foods
- Manner of dress and adornment
- Body language, particularly whether touching or close proximity is permitted in specific situations.

Avoiding Stereotypes

American society has developed many negative stereotypes and misconceptions about racial and ethnic groups based on perceptions of their use of alcohol and other drugs. These stereotypes should not be reinforced in the development of prevention materials. Any information on target groups used in the development of culturally appropriate messages and materials should be based on solid scientific and demographic research, not conjecture or "common knowledge."

You can incorporate these concepts into your messages and materials in

many ways, some of them quite subtle. For example, in many Hispanic culture, a hug is a demonstration of affection while in some East Asian cultures a hug is an invasion of personal body space. Thus how the characters in a television public service announcement interact can be as powerful a cultural message as the actual dialog between them.

Similarly, in many African-American, Asian, and Hispanic cultures, young people lower their eyes when spoken to by adults as a symbol of deference to authority. However, other cultures, particularly those with roots in Western Europe, see lack of eye contact as an indication that the person is being less than truthful. Thus a young person may be directed to "look in my eyes when I'm talking to you" by a White person and told "don't you dare look at me" by an elder of his or her own community.

Additional Ways To Target Audiences

Messages and materials also must respect the variations within cultural groups. Racial and ethnic groups are not monolithic. For example, although much of the recognized "mainstream" culture in the United States is drawn from Western Europe, people of European descent represent a multiplicity of religious backgrounds, national origins, traditions, customs, and folklore.

People within any racial, ethnic, language, nationality, or religious group are not homogeneous even though they may hold many cultural beliefs, practices, and institutions in common. Some of the major areas of difference within groups include:

- Age
- Gender
- Sexual orientation
- Education level
- Occupation
- Geographic area
- Income
- Adherence to folk customs and beliefs
- Presence or lack of disabling condition
- Health status
- Alcohol, tobacco, and other drug beliefs and practices
- Preferred language
- Citizenship, immigrant, or refugee status.

These elements must be taken into account in the design and implementation of culturally specific messages and materials.

For example, teenagers in the United States are often viewed as having a culture of their own that is quite distinctive from that of adults. However, trying to target messages and materials to members of a "youth culture" within the United States, using age parameters only, has often proved unsuccessful. This is because the share values and history of African-American youth are so different from those of youth of European ancestry and youth from other cultures.

These differences among youth of various races and ethnicities include:

- Musical preferences, such as rap, heavy metal, salsa
- Style of dress
- Media choices, including radio stations and magazines
- Importance of religion
- Favorite sports and sports figures
- Dating rituals
- Use of alcohol, tobacco, and other drugs
- Leisure time activities.

As a result, in many communities there is no youth culture that is sufficiently homogeneous across race and ethnicity to stand as an alternate cultural grouping. In these communities, it is often wiser to target first based on classic cultural definitions (race, ethnicity), adding youth as a secondary targeting criterion.

The second level of targeting is often important. For example, use of rap music in a prevention message may be quite effective in reaching young African Americans. However, the same music can alienate older African Americans who often reject this musical form as "noise."

Is There a Role for General Market Messages?

Until quite recently, the preference for many programs was to try to reach everyone with a basic message rather than targeting messages to specific groups. The rationale for this broad-brush approach included:

- The feeling that we all respond to the same elements of American culture in messages and materials
- The belief that a good prevention message could be so powerful that it would reach all groups equally
- The perceived divisiveness of doing separate ("segregated") messages and materials for different groups
- The lack of time, money, and expertise to develop separate, culturally

specific campaigns and the risk of omitting some groups entirely.

Some of these arguments still make sense. Generally, even persons with roots in other cultures can understand messages that use the images, symbols, and language of the primary culture of the nation in which they reside. But they may not truly feel the message in the same way that they would if the communication had specific meaning for their own culture. Messages geared toward specific cultural groups are often far more effective than general market messages in changing attitudes regarding problem use of alcohol, tobacco, and other drugs.

Yet this does not mean that there is no longer a place for any general market messages. Some media - such as television and daily newspapers - reach the general public. For these media, broad messages still are important. Still, general market messages should be augmented, whenever possible, with more targeted messages that are much more specific in their reach to designated audiences.

And even when targeted messages are used, cultural sensitivity should still be part of the design of any general market messages. This means that even if you have specific campaigns designed to reach African Americans or Asian Americans, your general market campaigns also should be appropriate for these groups as well as for the majority culture. This does not mean that every general market prevention message requires a "United Nations" approach with each target group represented visually. However, all messages and materials should be inclusive, and none should contain elements that are offensive or inappropriate to any segment of the population.

Race, ethnicity, and culture are not the only factors that can be used to segment an audience.

However, all market segmenting should take race, ethnicity, and culture into account in developing messages that will be accepted by specific market segments, such as women, gays, youth, agricultural workers, the elderly, or the poor.

Important Steps for Developing Culturally Appropriate Messages and Materials

Developing culturally sensitive and effective messages and materials for your prevention programs and projects can be challenging. Some steps that can help, which are adapted from the first three stages of the six-stage ATOD communications process as illustrated in the diagram below are as follows:

- **Gather general information on the issue you plan to address.** For example, are there particular ways that alcohol, tobacco, or other drugs have historically been used within the culture? Are the rates of use higher or lower than in the general population or skewed differently with respect to age, gender, or socioeconomic status? You should do your homework before you approach the community for help in designing a program.
- **Decide what specific issue or problem you will address.** Determine your focus: nonuse of alcohol, tobacco, and other drugs for youth or pregnant women? Moderate alcohol use for adults? Community action against illicit drugs? Decreased availability of alcohol and tobacco products for youth? Your ideas should not be set in stone because the community may have its own perspective on the most important problems they face with alcohol, tobacco, and other drugs. However, you should have some starting point for discussion.
- **Define and understand your specific target audience.** Identify key items such as race, ethnicity, nationality, religious preference, geographic boundaries, age, gender, and cultural preferences. Be as specific as possible. Don't assume that national data can truly describe your population. Involve knowledgeable community leaders in a needs assessment process so that you know exactly whom you are targeting with proposed messages and materials.

*Cultural sensitivity
should be a factor
in the design of all
organizational
communications,
including speeches
and news releases
- not just in
targeted public
service
announcements,
brochures, and
special media
campaigns.*

Targeted Media Channels

Part of your challenge will be to identify media channels that reach various racial, ethnic, and other specialized audiences. Many groups have their own media, particularly newspaper and radio stations. In communities with large concentrations of Hispanics, there may be Spanish - language television networks and programs. African Americans can often be reached through syndicated programs designed for African-American audiences and local public affairs programs. Leaders from the community can help you to identify key media.

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Racial and Ethnic Terms

- **Identify the channels that can best reach the audience and how those channels actually**

Words are very important in the development of culturally sensitive messages and materials. Terms that refer to race and ethnicity often have both overt and hidden meanings. For example, many people of color resent use of the words "minority" and "non-White." Whenever possible, you should use the descriptive term that is preferred by the majority of persons in that specific target group. This may be a nationality-based -- such as "Japanese" or "Lakota" -- or broader term like "persons of color." In some instances, it is preferable to use a combination of accepted terms.

y are used by the audience. Choosing the appropriate channels can be complicated. Although demographics may show that most of the target audience watch general market media such as television and daily newspapers, they may place more credibility in media that are owned or controlled by members of the target audience. It is often a good idea to combine general market and target market media to increase the number of times your message is seen or heard and the number of people who see or hear it. Sometimes interpersonal and community channels such as church bulletins, flyers posted at the corner grocery or laundromat, group meetings, loud speakers on cars or trucks that circle the neighborhood, or printed T-shirts can be quite effective in reaching a specific audience with a prevention message.

- **Develop preliminary concepts in concern with people who are representative of your target audience.** An effective way to do this is to identify members of the target population who are respected and influential within the community and enlist their help in the planning process. (Remember, these individuals who are best known and have most stature in the larger, mainstream society.) Leaders will vary from one group to another. They may hold formal rank within the religious structure, operate within informal spheres of influence, serve as teachers or counselors, have leadership positions within a youth group or gang, or be elders who are seen as wise men and women. Gaining the support of people who represent your target audience can provide invaluable insight into the needs, beliefs, and customs of the audience.
- **Test the preliminary concepts with the intended audience.** Even though you involve representatives of the target community in the development of concepts, it is still important to test the concepts in order to check the cultural appropriateness and potential effects on the issue or problem you are addressing. This can be done through use of focus groups, interviews, and questionnaires. It is often advisable to use skilled and knowledgeable individuals who accurately understand the community (and preferably are from the community) to ensure that the information received truly reflects the community's feelings and beliefs. Concept testing allows you to see how messages are received and understood.
- **Work in concern with community-based experts to develop or select specific messages and materials that use the pretested concepts.** The messages and materials should be those that are most effective and that can be best communicated through the selected communication channels that best reach the target audience. A message that will be carried primarily on non-English radio may be quite different from one that will be primarily print. Furthermore, if a message is designed to be communicated primarily by word of mouth, the basic message would be clear and concise enough so that the prevention concepts do not get lost or confused as part of the spoken process.
- **Field test the messages and materials with the intended audience.** Even when the preliminary concepts have been tested and the specific messages are designed in concert with representatives of the targeted community, you should pretest the actual messages and materials before a major campaign is launched.

Messages and
materials for a target
audience should
always be:

always be:

- Pretested with the prospective audience
- Scientifically accurate and substantiated by reliable data
- Suitable for the audience in reading level, language, images, and choice of words.

Borrowing From Other Programs

It is not always necessary to start from scratch. Often you can use materials from other programs that have targeted prevention or health messages to similar audiences. Be careful, though. Be sure that the audiences are really similar. An outreach program for Asians on the West Coast may not be effective in a Midwestern small town. Or materials that were developed for a recently arrived Mexican farm worker population may not be readily accepted by Mexican Americans with roots in this country that go back three or four generations. Testing messages and materials with your target audience will reveal whether adaptations are needed.

- Failing to involve members of the target group in the development and selection of messages and materials.
 - Ignoring variances and diversity within a racial or ethnic group.
 - Assuming use of targeted media will automatically make a message acceptable to the target audience.
 - Try to target a single message to an audience that is too diverse.
 - Using terms or language that is offensive to the target group.
 - Assuming that selecting a spokesperson from the target group, such as a popular athlete or entertainer, will turn a general market message into a targeted message.
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- Make revisions as necessary, based on audience reactions and results. When creating culturally sensitive and effective materials for target populations, it is easy to make mistakes. A second round of pretests can help to correct these. If problems arise, you may find it necessary to go back to the drawing board, make revisions, and pretest the messages and materials again until they truly serve their purpose. This is part of the fine tuning and can prevent misunderstandings.

Creating culturally sensitive and effective messages and materials is not easy. But the results are well worth the extra effort. Simply striving for inclusiveness in general market messages is not enough -- particularly in trying to change attitudes that lead to problems with alcohol, tobacco, and other drugs among racial and ethnic groups. Only when the people we are trying to reach see themselves and their cultures reflected back in our messages and materials can we expect to see the changes in attitudes and awareness that we seek.

Reference/Resources

The following references and resources can provide background and additional information on communicating with culturally diverse audiences.

Axelson, J. *Counseling and Development in a Multicultural Society*. Monterey, CA, Brooks-Cole, 1985.

Kumabe, K.I., Nishida, C., and Heyworth, D.H. *Bridging Ethnocultural Diversity in Social Work and Health*. Honolulu, University of Hawaii School of Social Work, 1985.

National Clearinghouse for Alcohol and Drug Information (NCADI), Box 2345, Rockville, MD 20852, (301) 468-2600 or (800) 729-6686. Provides information the research literature, programs, and educational materials.

Orlandi, M., Weston, R., and Epstein, L.G., *Cultural Competence for Evaluators: A Guide for Alcohol, Tobacco, and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities*. Washington DC, Center for Substance Abuse Prevention (CSAP), Division of Community Prevention and Training/Department of Health and Human Services (DHHS), 1992.

Putsch, R.. Cross-cultural communications. *Journal of the American Medical Association*, 1985; 254, 3344-3348.

Randall-David, E. *Strategies for Working With Culturally Diverse Communities and Clients*. Washington, DC, Office of Maternal and Child Health (OMCH)/Department of Health and Human Services (DHHS), 1989.

Glossary of Key Terms

Culture: The shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, language, nationality, or religious.

Cultural Competence: A set of academic and interpersonal skills that allows individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community - based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing targeted interventions, communications, and other supports.

Cultural Diversity: Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. A community is said to be

community, organization, or nation. A community is said to be culturally diverse if its residents include members of different groups.

Cultural Sensitivity: An awareness of the nuances of the one's own and other cultures.

Culturally Appropriate: Demonstrating both sensitivity to cultural differences and similarities and effectiveness in using cultural symbols to communicate a message.

Ethnic: Belonging to a common group -- often linked by race, nationality, and language -- with a common cultural heritage and/or derivation.

General Market Messages: A message intended for a broad audience.

Language: The form or pattern of speech -- spoken or written -- used by residents or descendants of a particular nation or geographic area or by any large body of people. Language can be formal or informal and includes dialect, idiomatic speech, and slang.

Mainstream: A term that is often used to describe the "general Market." This term usually refers to a broad population that is primarily White and middle class.

Multicultural: Designed for or pertaining to two or more distinctive cultures.

Nationality: The country where a person lives and/or one that he or she identifies as a homeland.

Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.

Religion: A system of worship, traditions, and belief in a higher power or powers - often called God - that has evolved over time, linking people in a commonality of reverence and devotion.

Targeted Message: A message designed to appeal to a specific group or subset of the general market. The target audience can be based on race, ethnicity, age, gender, income level, occupation,

based on race, ethnicity, age, gender, income level, occupation, health status, behavior, or a combination of these or other factors.



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Developed and Produced by the CSAP Communications Team.

Patricia A. Wright, Ed.D., Managing Editor.

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This bulletin is one in a series developed to assist programs that are working to prevent alcohol, tobacco, and other drug problems. We welcome your suggestions regarding information that may be included in future bulletins. For help in learning about your audience, developing messages and materials, and evaluating communications programs, contact the CSAP Communications Team, 7200 Wisconsin Avenue, Suite 500, Bethesda, MD 20814-4820, (301) 941-8500.

Technical Assistance Bulletin

A Key Step in Developing Prevention Methods Is To Obtain Expert and Gatekeeper Reviews

September 1994

Why Do It?

You can mount a successful alcohol, tobacco, or other drug (ATOD) problem prevention campaign or educational program without advanced degrees in medicine, law, education, psychology, sociology, or media production. But all of these fields can come into play when you develop a video or even a simple brochure. Obtaining advice from expert reviewers in these and other fields can help to ensure that your prevention message has a solid scientific foundation, that it will not raise unforeseen legal difficulties, and that it will appeal to its intended audience.

Another form of review is the gatekeeper review. A gatekeeper is a representative of an intermediary organization -- such as a church or school -- that has direct contact with your target audience. The term indicates that you must pass through this "gate" to get to your audience. A gatekeeper has the power to accept or refuse the materials you are developing. A gatekeeper may identify elements of your message that run counter to the organization's policies or goals. The gatekeeper's concerns may include such issues as stereotyping or racism, grammatical preferences, failure to observe the cultural norms of the audience (e.g., introducing the subject matter too quickly), whether you have excluded important steps or types of people.

Addressing the gatekeeper's concerns during the development of the materials can facilitate the distribution of the materials once they are completed. These keepers can open the gate for you and provide opportunities of entrance to the target audience. This may be particularly true if members of the target audience are distrustful because historically the group you may represent -- such as Government, Whites, the "establishment" -- has not been perceived as trustworthy.

The gatekeepers can assist in helping you identify culturally appropriate reviewers as well as the major policy makers and opinion leaders. They may even provide assistance on the best ways to approach them and when.

Expert and gatekeeper reviews are not a guarantee of success. They should be used in conjunction with other pretesting procedures designed to gauge the reaction of the target audience and those who may use or distribute the materials. While focus groups or theater interviews can provide feedback on the effectiveness of your message with the target audience, experts can provide feedback on the accuracy of your message.

This bulletin tells how to lay the groundwork for a successful review procedure. It includes recommendations for identifying qualified experts and getting their help.

What to Do

Step 1: Get CSAP Guidelines

The Center for Substance Abuse Prevention (CSAP) has established guidelines designed to help prevention professionals develop educational and prevention materials. These guidelines will start you in the right direction and help you avoid the pitfalls that can undermine a campaign to prevent alcohol, tobacco, and other drug problems. Write or call the national Clearinghouse for Alcohol and Drug Information (NCADI) and ask for "Communications Programs Can Help To Prevent Alcohol and Other Drug Problems" (MS 397). P.O. Box 2345, Rockville, MD 20852. (301) 468-2600 or (800) 729-6686.

Step 2: Determine Types of Reviews Needed

Your message and the audience you intend to reach will determine the kind of expert and gatekeeper reviewer you need.

- **Health care providers or medical research scientists** can provide feedback on the accuracy and completeness of messages concerning the physical effect of alcohol, tobacco, and other drugs.
- **Legal professionals** can provide feedback on messages concerning the legality of specific alcohol, tobacco, and other drug-related behaviors and penalties for conviction.
- **Law enforcement officials** are on the frontline of the war on drugs and can provide feedback on messages concerning the consequences of drug-related behaviors such as drinking and driving.
- **Social workers** can provide feedback on messages concerning the effect of alcohol, tobacco, and other drug use and abuse on the community, the family, and the individual.
- **Principals, teachers, or school counselors** may serve as gatekeepers for their schools. They may identify elements of your message that run counter to school policy, or they may suggest issues that need to be added.
- **The clergy** -- priests, rabbis, ministers, imams, and other religious leaders -- may serve as gatekeepers for their memberships. They may indicate revisions that would make your materials readily acceptable for distribution to groups within their community.

Others that may provide an expert or gatekeeper review, depending on your target audience and the medium you are using, include the following:

- **Tribal leaders**
- **Leaders in service clubs, fraternities, or sororities**
- **Media representatives**
- **Youth-serving organization leaders** - of, for example, boys or girls clubs, and scouts
- **Nonprofit organizations at the State or local level** -- such as national Association for Children of Alcoholics (NACOA), March of Dimes, The Links
- **Curandero**
- **Regional Alcohol and Drug Awareness Resource (RADAR) network centers.** Call the National Clearinghouse for Alcohol and Drug Information at (301) 468-2600 or (800) 729-6686 to get the phone number and address of the nearest network center or one of the specialty RADAR network centers for, for example, African Americans, Hispanics, people with disabilities, children of alcoholics, or American Indians.
- **State centers of the National Prevention Network (NPN).** Call the NPN's national office in Washington, DC, to get the number and address of the NPN center in your State. 444 North Capitol Street, NW, Suite 642, Washington, DC 20001. (202) 783-6868.

Step 3: Locate Reviewers

You may already have several professional contacts who can serve as reviewers. But if you need help, a number of organizations or institutions can help you to identify the most appropriate reviewers.

The public relations department of a local college or university may have a list of faculty members with the expertise to review your materials for scientific accuracy.

To locate appropriate gatekeeper reviewers, identify an organization that serves your target audience. Choose an organization that can lend credibility to your message with its endorsement. Contact representatives of the organization and provide a clear statement of your ATOD problem prevention message, your strategy, and your goals.

Among many groups, you will need to ensure that you have a clear message about what you will be giving to that community. You cannot assume that, just because you think you are "doing something good," the gatekeepers will agree. Many others might have come before you just to take information -- or property -- without giving anything in return.

Step 4: Ask for Help

When requesting the services of a reviewer representing a specific cultural or ethnic group, be sensitive to the specific protocol of that culture. For example, while some cultures value moving directly toward reaching an agreement, others may require a process of establishing personal connections before entering a business relationship.

Always indicate clearly how long the reviewer may take with the material under consideration. Make sure that everyone understands the amount of time and effort that will be required and when the materials are to be returned.

An expert or gatekeeper may have a wealth of knowledge that would be valuable to your project. But unless you inform that reviewer of what you want to know, he or she may make some incorrect assumptions about what you need.

You can make the job of your reviewer easier by providing a short background statement about the product to be reviewed -- including a description of the target audience, the materials' purpose and use, and, if appropriate, the benefit to the reviewer's constituency. Provide a set of specific instructions or questions. This will also help to ensure that you receive the kind of feedback you are looking for.

If your instructions are general, the reviewer may assume that you are not looking for specific comments. The result may be a brief statement of approval for your efforts or very general comments about strengths and weaknesses.

Without instructions, a reviewer might focus on aspects of the message that you are unwilling or unable to change. In some cases it may be helpful to let the reviewer know what other experts have contributed. For example, if you are seeking advice from a teacher of inner-city youth, you might indicate that the scientific aspects of the material have been reviewed or are being reviewed by medical professionals. This will help the teacher to focus on the appropriateness of the style, format, and appeal of the message rather than on the scientific and medical accuracy of the content.

You may want to solicit reviews from a variety of experts who can respond to the different aspects of your draft materials. The examples that follow illustrate how a prevention team might seek advice on the same brochure from two different kinds of reviewers.

Sample Letter and Questions:

Dear Officer Smith:

Thank you for agreeing to review the enclosed brochure "How To Survive Prom Night." The brochure is being developed by our organization for distribution to area high schools. Our goal is to convince high school students to abstain from drinking, especially on prom night. We are counting on your experience as a police officer who knows the consequences for students who drink and drive to judge the accuracy of the brochure's statements about his danger. We are also asking guidance counselors from three area high schools to evaluate the brochure for conformance to school policy and procedures and an area judge to evaluate the brochure's statements about legal penalties.

As you review the brochure, please answer the following questions:

1. Is the scenario for the automobile crash described on page 3 realistic?
2. Are the arrest procedures described on page 4 accurate? If not, what can a student expect if stopped for suspected driving under the influence of alcohol?
3. If you were talking to an assembly of high school students, would you be willing to distribute this brochure? If not, why not?
4. Are there any additional facts or ideas that you would like included?

Thank you, again, for providing this service. We are depending on your contribution to ensure the accuracy and credibility of this brochure, and we will make every effort to incorporate your suggestions into the final product.

We need your comments by (date). Please contact me or my colleague, Mr. Jackson, at (phone number) if you have any questions.

Sample Letter and Questions:

Dear Dr. Jones:

Thank you for agreeing to review the enclosed brochure "How To Survive prom Night." The brochure is being developed by our organization for distribution to area high schools. Our goal is to convince high school students to abstain from drinking, especially on prom night. We are counting on your knowledge of policy and procedures at Harrison High School to identify any potential conflicts with statements in this brochure. We are also asking a police officer to judge the accuracy of the brochure's statements about automobile crashes and arrest procedures, and an area judge to evaluate the brochure's statements about the legal penalties for conviction of driving under the influence of alcohol.

As you review the brochure, please answer the following questions:

1. Do any of the recommendations in the brochure conflict with your school's policies or procedures?
2. Would you be willing to distribute this brochure to students in your high school? If not, why not?
3. In your opinion, will the brochure help convince high school students to abstain from drinking on prom night? If not, what would you change to make the brochure more convincing?
4. Are there any additional facts or ideas that you would like included?

Thank you, again, for providing this service. We are depending on your contribution to ensure that this brochure complements and reinforces your school policy. We will make every effort to incorporate your suggestions into the final product.

We need your comments by (date). Please contact me or my colleague, Dr. Jones, at (phone number) if you have any questions. If your questions to reviewers are clear, specific, and appropriate, you should expect to receive useful information. Remember that everyone is busy, so you may need to call

a reviewer if you have not received a response as your deadline approaches. You may also need to take the reviewer's comments over the phone. This will make the job easier for the reviewer but may not serve your purposes if you need a written record.

When seeking a review of materials targeting a cultural or ethnic group, ask at least one appropriate reviewer to address the authenticity and suitability of the medium. For example, while it may seem to be a good idea to present prevention messages through a rap song, your reviewer might find language in your message that is inconsistent with rap - or rhythms that would be more appropriate for a nursery rhyme. Or even though the target audience may be members of an ethnic minority, they may not relate to rap.

Other considerations that you might ask one or more appropriate reviewers to focus on include cultural sensitivities and the presence of negative stereotypes. Your reviewer may be able to suggest the inclusion of such cultural factors as the importance of the family, the key role of grandparents, and religion. Your reviewer might also detect biases in your material that could perpetuate a myth or stereotype about a group of people. For example, your reviewer may ask you to revise a play in which everything good is portrayed with white symbols and everything bad with dark symbols. Be sure to ask questions that will elicit this type of response.

Step 5: Use What You Get

Take your reviewers' comments seriously and use them in revising your materials. Since you have received the commitment of your reviewer by describing the benefits of your product for the target audience, ensure that your materials provide those benefits by incorporating your reviewer's comments. If a reviewer's comments seem unclear, try to obtain clarification. Never ignore a reviewer's contribution or treat it as a meaningless formality. The reviewer who takes the time to aid your project will want to see the evidence of his or her work in the finished product.

One mistake that message developers in all fields often make is to underestimate the importance of the review process. As a result, they designate a production schedule that assigns review to a last-minute position. Consequently, if the review reveals major problems with the prevention message, there is not time to correct the error fully.

- Begin the review process as soon as you have something concrete to show your reviewers.
- Allow yourself time to make major and fundamental changes in case the comments of your reviewers indicate that such changes are needed.
- Give your reviewers enough time so that they can give your work more than a cursory review.
- Let them know what your deadlines are so that they do not hold the work too long.

Your production schedule would include opportunities for review at each state of product development. Designating time to have your product evaluated can save you from unexpected delays caused by errors discovered too late.

What Other Help Is Available?

In addition to your local network, you will find it useful to be in touch with prevention colleagues in your State and at the national level. The National Association of State Alcohol and Drug Abuse Directors (NASADAD), 444 N. Capitol St. N.W., Suite 642, Washington, DC 20001, (202) 783-6868, and the RADAR network can help you to identify the official within your State who is responsible for alcohol, tobacco, and other drug problem prevention programs. That official, in turn, may be able to help you to identify more experts within your area.

The CSAP Communications Team may be able to suggest expert reviewers and to help with the next phase of pretesting your materials. As your materials enter the final stages of development, you should ensure that they are in compliance with the CSAP message and material review guidelines. Once your materials have been completed and submitted to NCADI for final review, they will be listed in the NCADI database as reference for others developing prevention messages and materials.

*Please feel free to be a "copy cat" and make all the copies you want.
You have our permission!*

**Developed and Produced by the CSAP
Communications Team.**

Patricia A. Wright, Ed.D., Managing Editor.

Distributed by the National Clearinghouse for Alcohol
and Drug Information, P.O. Box 2345, Rockville, MD
20852.

This bulletin is one in a series developed to assist programs that are working to prevent alcohol, tobacco, and other drug problems. We welcome your suggestions regarding information that may be included in future bulletins. For help in learning about your audience, developing messages and materials, and evaluating communications programs, contact the CSAP Communications Team, 7200 Wisconsin Avenue, Suite 500, Bethesda, MD 20814-4820, (301) 941-8500.

**The National Clearinghouse for Alcohol and Drug
Information**
A service of SAMHSA

Rural Center for AIDS/STD Prevention

FACT SHEET

Number 10- 1997

Developing Rural HIV/STD Prevention Education Programs

Rural communities face unique challenges in implementing HIV/STD prevention education programs. For example, in urban areas pre-existing high risk groups (e.g., homeless, drug addicted, prostitutes) have been specifically targeted for HIV/STD prevention programs.(1) In rural areas, specific identification of high-risk groups may be difficult.

The Centers for Disease Control and Prevention (CDC) has recommended that community HIV/STD prevention programs be designed to reach less accessible or identifiable populations.(1) In general, persons living in rural areas are more difficult to reach with HIV/STD prevention education than those living in urban areas. Some HIV/STD education programs seek community wide changes in social norms. This strategy has advantages in rural areas.(2) CDC has recommended the use of social marketing theory as a basis for modifying community norms.

Social Marketing Theory

Social marketing is a method of convincing community members to practice HIV/STD prevention. The target audience must perceive that the benefits of prevention behaviors are greater than the barriers to the behavior. HIV/STD prevention behaviors include abstinence from sexual intercourse, using condoms for intercourse, and using sterile injection equipment.

Social Marketing Components

A combination of product, price, promotion, and place forms the basis for an effective community HIV/STD prevention education program. Use of condoms for HIV/ STD prevention is used to illustrate these components.

- The product (e.g., condom) must be perceived as beneficial by the user. Condoms should be marketed so that perceived barriers to use appear small compared to perceived benefits.
- The price should be reasonable for the audience. Many communities have made condoms available inexpensively or free.
- Promotion refers to the prevention message. The content and delivery of condom use messages should be based on the characteristics of the target audience, such as their attitudes, values, and behaviors.
- Place refers to an accessible location for distribution of the message and/or product (e.g., condom).

Social Marketing Steps

Effective social marketing programs involve several steps, each of which should be coordinated by a community planning group (CPG).(2,3) The CPG should include members of the target audience. Such persons can act as positive role models for the target audience and can help identify unique attributes of the audience. Additionally, prevention messages based on behavioral theories are more likely to be effective than those based on "knowledge campaigns" or moral appeals. Ideally, status assessment of the intended population involving several behavioral theories should occur before constructing intervention programs.(4)

STEP 1: Conduct research to understand the intended audience.(5)

- Identify the risk behavior determinants of the intended audience. For example, how do poverty and isolation contribute to not using condoms? What are the perceived benefits of engaging in the high risk behavior?
- Determine perceived benefits and barriers related to the adoption of the new behavior (e.g., condom use). Learn enough about the audience to understand how to convince them to practice HIV/STD prevention.
- Identify the prevailing norms of the target audience. For example, youth are likely to share behavioral norms which should be addressed in prevention education. Some groups may deny vulnerability to HIV infection and others may accept vulnerability but still not practice preventive behavior. Each group requires a different message.(6)

STEP 2: Create a barrier/benefit ratio that is clearly beneficial to the target audience. This ratio should be favorable to behaviors which have the potential to eliminate or lower risk of HIV/STD infection. Audience perception of the ratio is influenced by the product, price, promotion, and place components described previously.

- Based on an assessment of the target audience, create messages designed to maximize perceived benefits and minimize perceived barriers to HIV/STD prevention behaviors.

- Develop ways to minimize barriers associated with adopting the behaviors. For example, condoms should be available inexpensively or free at accessible locations.
- Select effective media for the dissemination of the message and employ leaders of the target audience as spokespersons for the prevention program.(7)

STEP 3: Conduct ongoing research of the audience which identifies possible program changes that would be required to maintain program effectiveness.

- The World Health Organization has developed several prevention indicators that can be used as measures of program effectiveness. These indicators include incidence rates of STDs at local clinics, condom sales/availability, and self reported increase in prevention behaviors by audience members.(8)
- Continue research to determine any changing perceptions of the audience. For example, has the barrier/benefit perception of the target audience changed? Like other marketing programs, new approaches may need to be implemented.

Examples of Prevention Programs

Rural areas throughout the world have benefitted from social marketing programs. This approach has also been applied in rural communities throughout the United States.

- A social marketing program in Brazil distributed 26 million low cost condoms in 1996, a 44% increase since 1995.(9)
- A social marketing program in Ghana was successful in providing prevention education to a less accessible rural male population.(10)
- Communities in Pennsylvania have implemented HIV prevention programs for gay men in rural areas. Barriers to reaching this population include unstructured gay communities and homophobic social norms.(10)
- An Iowa COG has sponsored the production of three HIV prevention educational videos for rural youth. Videos were developed for (a) secondary school females, (b) middle school youth, and (c) high-risk youth i.e., those in juvenile detention, young men who have sex with men, and substance abusers.(11)
- In Missouri, regional CPGs involved members from community-based organizations, civic groups, and other representatives of rural communities. These groups helped narrow the gap between HIV/STD prevention needs and local politics. Primarily a rural state, the Missouri State Department of Health sponsored a Holistic Harm Reduction Program, which is designed to meet the living needs of recipients. (V. Leighty, persona communication, November 13, 1997.)
- Delmarva Rural Ministries (DRM) is a private nonprofit organization that promotes HIV prevention to migrant farm workers and the rural poor in a tristate area of Delaware, Maryland, and Virginia. Programs included distribution of informational pamphlets, free condoms, and HIV information posters to persons in migrant camps.(12)

The combination of (a) social marketing, (b) behavior change theory, (c) community planning groups, and (d) target audience participation creates a promising approach to the development of effective HIV/STD prevention education programs for rural areas. CDC has titled these components, the Prevention Marketing Initiative (PMI). (2) Strategies for implementing PMI are available from CDC through the National AIDS Clearinghouse (call 1-800-458-5231 and ask for *Applying Prevention Marketing*).

Sources of Information

1. Morbidity and Mortality Weekly Review. (1996). Community-level prevention of human immunodeficiency virus infection among high risk populations: The AIDS community demonstration projects. *MMWR*, 45, (RR-6).
2. Ogden, L., Shepherd, M., & Smith W.A. (1996). *The prevention marketing initiative: Applying prevention marketing*. Atlanta, GA: Centers for Disease Control and Prevention.
3. Aggleton, P. (1997). Behavior change communication strategies. *AIDS Education and Prevention*, 9, 111-123.
4. Rural Center for the Study and Promotion of HIV/STD Prevention. (1995). Behavior Change Models for Reducing HIV/STD Risk. (Fact Sheet #3). Bloomington, IN:RCSPPH.
5. Ramah, M., & Cassidy, C.M. (1992). *Social marketing and the prevention of AIDS*. Academy for Educational Development.
6. Sumartojo, E., Carey, J.W., Doll, L.S., & Gayle, H. (1997). Targeted and general population interventions for HIV prevention: towards a comprehensive approach. *AIDS*, 11, 1201-1209.
7. Kelly, J.A. et al. (1997). Randomized, controlled, community-level HIV-prevention intervention for sexual-risk behavior among homosexual men in U.S. cities. *Lancet*, 350, 1500.
8. Mertens, T.E., & Carael, M. (1997) Evaluation of HIV/STD prevention, care and support: an update on WHO's approaches. *AIDS Education and Prevention*, 9, 133-145.
9. Anonymous, (1996). Condom social marketing boosts entire condom market in Brazil. *AIDS Captions*, 3, 36-38.
10. Friedman, M.S. (1997). *Strategies for HIV prevention planning among gay men in rural communities*. Paper presented at the annual meeting of the American Public Health Association, New York City, NY.
11. Centers for Disease Control and Prevention. (1997). Innovative or promising practices in HIV prevention, HIV prevention community planning, and application development. National Center for HIV, STD, and TB Prevention. Division of HIV/AIDS Prevention - Intervention Research and Support.
12. Zimmerman, M.A., Israel, B.A., Colman, S.S., & Prevots, D.R. (1995). Delmarva rural ministries, AIDS prevention for farm workers. In M.H. Becker, B.A. Israel, & N.K. Janz (Eds.) *AIDS prevention in the community* (141-145). Washington, DC: American Public Health Association.

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For information about the resources used for this FACT SHEET contact:

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World Wide Web: <http://www.indiana.edu/~aids/>

Applying Prevention Marketing

**it's
YOUR
move
prevent
AIDS**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL
AND PREVENTION

The Prevention Marketing Initiative:

Applying Prevention Marketing

February 1996

**Lydia Ogden and Melissa Shepherd
Centers for Disease Control and Prevention
with
William A. Smith
The Academy of Educational Development
and with
Porter/Novelli**

For additional copies of this document contact the Centers for Disease Control and Prevention's National AIDS Clearinghouse. (800) 458-5231

For more information about prevention marketing contact the Centers for Disease Control and Prevention. (404) 639-0956

List of Acronyms

AIDS	acquired immune deficiency syndrome
AIDSCOM	AIDS Public Health Communication Project
ASO	AIDS service organization
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CPG	community planning group
HIV	human immunodeficiency virus
IDU	injecting drug user
KABBs	knowledge/skills, attitudes, beliefs, and behaviors
KAPs	knowledge/skills, attitudes, and practices
MSM	men who have sex with men
NAC	National AIDS Clearinghouse
NMO	national minority organization
PMI	Prevention Marketing Initiative
PSA	public service announcement
RFP	request for proposal
RMO	regional minority organization
STD	sexually transmitted disease
TA	technical assistance
USAID	U.S. Agency for International Development

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Foreword

One of the Centers for Disease Control and Prevention's top priorities is preventing HIV transmission among people 25 and younger because this group now accounts for half of all new HIV infections. Nationwide, countless community-based organizations (CBOs), AIDS service organizations (ASOs), faith-based AIDS ministries, HIV Prevention Community Planning Groups, state and local health and education departments, other federal agencies, and national organizations share this goal. Some are already using various aspects of social marketing in HIV and sexually transmitted disease (STD) prevention programs, drug use prevention programs, and other public health efforts. Many HIV Prevention Community Planning Groups, in particular, have used key elements of social marketing in developing their plans. They have used epidemiologic and demographic data — combined with information about possible audiences gleaned through focus groups, individual interviews, and other means, to define priority groups and their needs and to guide decisions about interventions. What social marketing offers these groups and others is a new perspective and a systematic way to design, deliver, and evaluate prevention programs that are focused on behavioral goals.

This document is designed for a wide-ranging audience of those responsible for HIV prevention programs for young people. It was written to help organizations develop, deliver, and evaluate interventions by

- increasing understanding of the principles and processes of social marketing to reinforce or change behaviors to prevent HIV infection;

- providing a framework for creating, carrying out, and evaluating effective social marketing-based HIV prevention programs in community settings; and
- describing CDC's Prevention Marketing Initiative (PMI) and other interventions based on social marketing.

This document is divided into two parts. The first section describes social marketing — its key elements, real-life applications, benefits — and illustrates its principles with sketches of successful programs.

The second section lays out community guidelines for implementing social marketing-based HIV prevention programs. The recommendations in this section were developed by CDC and the Prevention Collaborative, an alliance of local, state, regional, and national public- and private-sector organizations working to prevent HIV transmission. On March 3–4, 1994, the Prevention Collaborative met in Washington, DC, to begin the process of developing these guidelines. Young people, both staff and constituents of member organizations, are an integral part of the Collaborative and of the development of these guidelines. At the March 3-4 meeting, attendees were asked to develop recommendations in five key areas:

- research and evaluation;
- linkage and integration with existing health, education, and social services agencies;
- coalition building;
- health communications; and
- community implementation.

Working groups were created to focus on each of these five topics. Additionally, the young adults formed an ad hoc group to discuss these five issues as well as other priorities, needs, concerns, and questions for HIV prevention and education focusing on young people.

A complete list of current Prevention Collaborative members is in Appendix A. Also included is a list of the Guidelines Working Group, which was nominated by the whole Prevention Collaborative to help develop this document, and the Resource Working Group, a team of state and community representatives involved with HIV Prevention Community Planning, who assisted in assuring the applicability of these guidelines in that setting. (For more information on applying social marketing within the context of HIV Prevention Community Planning, see Appendix B.) These two groups met in Washington, DC, on August 29, 1994, to refine a draft of this document and to develop additional recommendations for community-based social marketing programs.

This primer is one of the first steps in CDC's efforts to provide information and guidance on social marketing to HIV prevention program planners. More detailed technical assistance will be available in 1995 and beyond. CDC is working with the Prevention Collaborative and HIV Prevention Community Planning participants to define and develop that technical assistance and will incorporate findings and insights from the PMI local demonstration sites, five community projects that are applying prevention marketing in real life at the local level. (For more information on PMI and the local demonstration projects, see Appendix C.)

What Is the Prevention Marketing Initiative?

CDC's Prevention Marketing Initiative is a multi-level program that includes national activities (such as public service announcements and other television programming) and local activities to help communities improve the effectiveness of their HIV prevention programs through social marketing. In its first phase, begun in 1994, PMI focuses on preventing the sexual transmission of HIV among young people 18–25.

PMI is based on social marketing. A program funded in 1987 by the U.S. Agency for International Development (USAID) called AIDSCOM (AIDS Public Health Communication Project) demonstrated how social marketing can be used in HIV prevention. AIDSCOM contributed to the field of social marketing by adding strong behavioral science to program planning. Behavioral science examines people's behaviors in depth — who's doing what, with whom, where, when, how, and how often. Most importantly, behavioral science tells us *why* people behave as they do — what their knowledge is, what their skills are, what their beliefs are, what their attitudes are, and what motivates them. Knowledge, skills, attitudes, and beliefs combine to result in behavior, all of which is illuminated by behavioral science. AIDSCOM integrated program planning, social marketing, and behavioral and social sciences. PMI has capitalized on that experience.

In addition to social marketing and behavioral science, prevention marketing relies on a third critical component: community participation and action. Social marketing has always relied on target audience input for program materials — through focus groups, surveys, and other means. The community participation and action component is more than that. Prevention marketing relies on broad community mobilization and action to design, develop, deliver, and evaluate programs. It has as its foundation this belief: *Communities are experts in what their needs are, and, when equipped with supportive resources, are the best people to address those needs. Working with specialists in the sciences of behavior and communications, communities can best develop their own HIV prevention programs.*

Prevention marketing is CDC's "brand" of social marketing. Prevention marketing adds important qualities to social marketing with its emphasis on behavioral science and community participation and action. A key part of community mobilization is *issues management*, which systematically ensures that the media carry needed messages and information to audiences, including gatekeepers and other influentials. Competing, conflicting, and misunderstood messages can cripple community participation. Prevention marketing depends on constituents understanding issues and acting on them.

Prevention marketing is not a short-term solution. It's a long-term commitment — because changing and sustaining people's behavior is not accomplished overnight but over time.

For more information on PMI, see Appendix C.



A Rationale for New Approaches

Information Is Not Enough

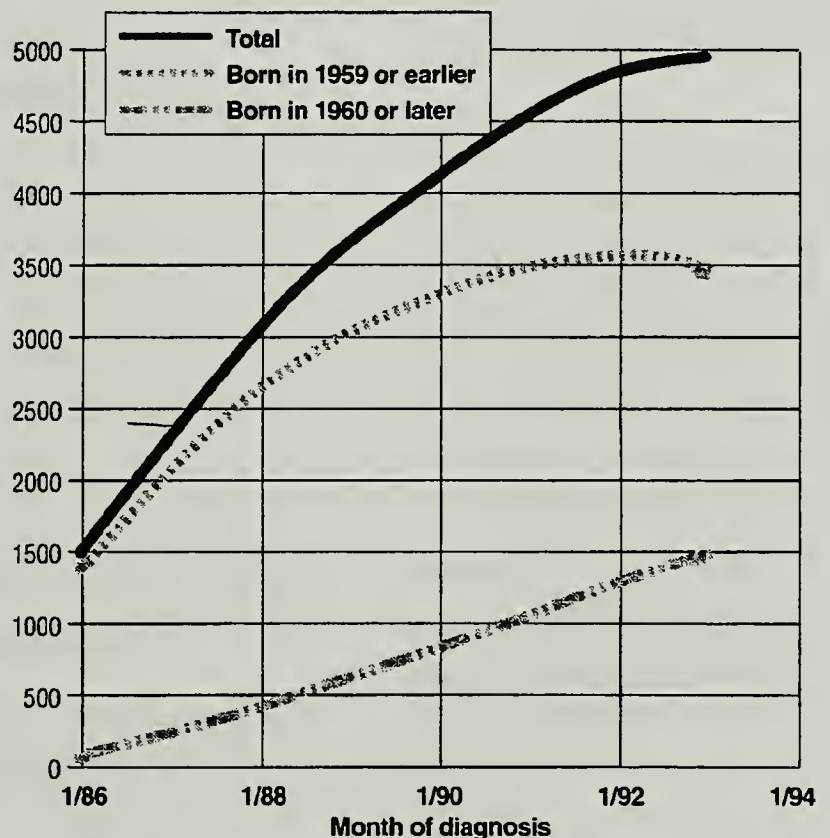
Accurate information about AIDS is critical to halting its spread. In the epidemic's early days, most prevention programs focused on giving people the facts about AIDS and HIV — what the disease is, how it's spread, what people can do to keep themselves safe.

But, as many people knew all along, information is not enough. Now, almost everyone knows the basic facts about HIV and its transmission. People need more than facts — they need support in changing behaviors that put them at risk.

Approximately 80,000 new HIV infections still occur every year among men, women, and children in the U.S. The CDC estimates that about a million Americans are infected with HIV, and many don't know they're infected. The median age of infection continues to decline,

AIDS cases in the U.S. population are still on the rise among young adults

AIDS cases are increasing much more rapidly among Americans born in 1960 or later.



Source: National Cancer Institute

as shown in the graph on the previous page. It is estimated that, by 1991, one of every four newly infected people was younger than 22 at the time he or she became infected. AIDS is now the leading cause of death among 25-42 year olds. Men who have sex with men account for approximately 43% of people with AIDS in America. New HIV infections and AIDS are increasingly reported among women and people who are racial/ethnic minorities. As the epidemic spreads to new populations, prevention programs must respond to new needs and perceptions with new ways of communicating, new messages, and new understanding.

Social Marketing Focuses on the Audience

Applying Proven Private-Sector Marketing Techniques to Health

Social marketing uses many of the tools of private-sector marketing — chiefly, intensive audience research — to guide program development and delivery. But instead of selling a product, like a car or detergent, a social marketing-based program “sells” behaviors that benefit both the individual and society. In the case of HIV prevention, behaviors could include...

choosing not to engage in sexual activity,
abstaining from penetrative sex,
not using unclean needles, or
using condoms.

Over the past 40 years, social marketing interventions to discourage smoking, promote seatbelt use, and prevent heart disease have shown that tailored messages delivered through credible channels and bolstered by appropriate support services can change people's health behaviors.

Social marketing's successes are the result of much more than just mass media, public service announcements, or advertising campaigns. Social marketing has three key features:

- *thoroughly understanding how and why “consumer segments” (target audiences) behave as they do;*

Social Marketing in Action

■ *In the U.S., the National Cancer Institute used a social marketing campaign focusing on African-American women to increase early detection of breast cancer. The number of Black women who got mammograms rose from 28% in 1987 to 62% in 1992.*

■ *The National Heart, Lung, and Blood Institute has used social marketing to guide a 22-year-long multi-dimensional campaign to decrease untreated high blood pressure. As a result, more than 95% of Americans have their blood pressure checked at least yearly, an increase of more than 40% since the campaign began.*

■ *A social marketing program in the Eastern Caribbean targeted sexually active youth and their parents with messages centered on sexual responsibility and family communication. The comprehensive campaign reached more than 90% of the target audience. It resulted in a significant increase in the number of people who thought parents and teens must talk about sexual responsibility. The campaign also triggered a sharp increase in the number of people who said they believed their partners wanted to use condoms and who believed that their friends used condoms.*

Social Marketing in Action

■ In Ghana, a comprehensive AIDS prevention program was developed using social marketing processes. The intervention used television and radio spots, comic books, key rings, T-shirts, a school outreach program including movies, discussions in popular TV and radio series, and articles in news media. A key message was HIV's incubation period; another was about safer sex. The campaign had these results: More than half of the hard-to-reach rural male population was reached; the number of people who understood HIV's incubation period increased by almost 20%; sexual activity decreased significantly among youth; and sexually active men reduced their number of sexual partners.

■ In the U.S., complete social marketing programs have not been extensively applied to HIV prevention efforts. CDC's Prevention Marketing Initiative is based on social marketing, and is posting some promising results in its first year. (For more information on PMI, see page 4.) Community-based programs that choose to use social marketing in their prevention efforts will be at the cutting edge of applying this tool to prevent HIV infection.

■ According to the World Health Organization, vigorous AIDS awareness and condom promotion campaigns have been conducted in Vanuatu, a republic comprising 82 Pacific islands between Fiji and New Caledonia. Field workers hired by the Department of Health ensured that pharmacies, stores, markets, nightclubs, bars, hotels, and other sites had a ready supply of condoms. The national AIDS program developed billboard messages in Bislama, a common language that is a form of Pidgin. The estimated 150,000 inhabitants of Vanuatu speak 115 distinct Melanesian languages.

- *creating beneficial exchange relationships (exchanging an unhealthy behavior for a healthy one to get some perceived benefit) to influence those behaviors; and*
- *strategically managing prevention programs by continuously monitoring and altering interventions as needed to stay relevant to targeted audiences.*

The Audience, The Audience, The Audience

"What are the three most important things in selling a house?" goes an old saying in real estate. The answer: "Location, location, location."

What's the most important thing in a successful social marketing program? "The audience, the audience, the audience."

Social marketing and behavioral science study what influences and motivates certain behaviors among groups of people. Only then are strategies to affect those behaviors — either to change or sustain them over time — designed and implemented.

Virtually all program decisions are therefore based on audience research. Any behavior is viewed as a choice among many competing options. The program planner's task is to know why a certain option is more compelling to people than other options, and then to design prevention programs that use the concept of beneficial exchange to increase the appeal of the desired behavior or decrease the appeal of the undesirable behavior.

How Do We Get To Know An Audience?

Perhaps more than any health challenge of the last several decades, preventing infection with HIV and other STDs requires an understanding of some of the most complex and

intimate human behaviors. Social marketing places tremendous emphasis on knowing as much as possible about targeted audiences and their behaviors and what determines those behaviors. It uses a variety of measures to get that knowledge. This process is often called formative research, because it forms the basis of the program plan. (For more information on formative research, see page 42.)

People analyze various kinds of data as part of formative research, including information in the following areas.

Epidemiology

Epidemiology — the science of disease patterns — gives program planners information about the people affected by a given health problem. In HIV prevention, epidemiology gives us invaluable information about:

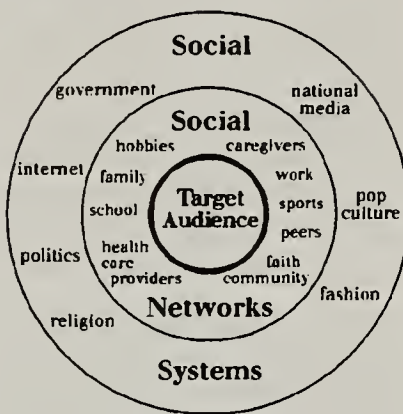
- **Seroprevalence:** Who is infected with HIV? How did they get infected? What does this tell us about prevention objectives?
- **Incidence of HIV Infection and AIDS:** What is the number of new infections or new diagnoses of AIDS in given groups? What does this tell us about where we might want to concentrate our prevention efforts?
- **Prevalence of AIDS:** How many people within a given group already have AIDS? What does this tell us about how the disease has progressed in the past? How it might progress in the future? What about the relative risk for people within the group to continue to spread infection?
- **Surrogate Indicators:** The incidence and prevalence of STDs, teen pregnancies, drug use, etc., can reveal key information about populations at risk for HIV infection.

Demographics

Demographic data give program planners information about target audiences' characteristics, including:

- race/ethnicity
- sexual orientation
- where they live
- religion
- how old they are
- marital status
- education level
- income.

Spheres of Influence



Psychographics

Psychographics adds to the picture by contributing information about:

- what the targeted audience's hopes and fears are
- what they do for work and recreation — where they spend their time, what's fun to them
- how they view themselves in the world
- who they associate with — their peers, people whose opinions they value
- whether they are innovators — willing to try new products, roles, activities, ideas, etc.
- what their social norms are — what they and their peers find valuable, believable, useful, worthwhile
- what their dreams are.

Psychographics gives program developers detailed information about the spheres of influence that affect the target audience and its behavior.

Media habits and other lifestyle factors

To begin narrowing the prospects for channels of communication, program planners gather information about the target audience's media habits and other lifestyle factors:

- what they watch

- what they listen to
- what they read
- how often they watch, listen, or read
- how much and how long
- where
- when
- other ways they get information
- what their behaviors as consumers are.

KABBs or KAPs

Knowledge/skills, attitudes, beliefs, and behavior surveys (or knowledge/skills, attitudes, and practice surveys) are at the heart of knowing the target audience.

- **Knowledge/Skills:** Program planners need to understand without a doubt what a target audience knows about program-specific topics. For example, what does the target audience know about using latex condoms versus natural membrane condoms to prevent transmission of HIV and other STDs? Do they know whether pre-cum (pre-ejaculate) is risky? What about double-bagging (using two condoms at once)? And so on. Skills are also critical. Can those in the target audience negotiate safer sex with a new partner? With a long-time partner? Do they put condoms on correctly? Can they correctly withdraw from a partner after ejaculation?
- **Attitudes:** For example, how does the target audience feel about abstaining from or delaying sexual activity? Does “holding out” indicate they don’t love their boyfriend or girlfriend? Does being a virgin mean you’re cool, or does it mean you’re a prude, or doesn’t it matter one way or the other? If a girl has sex, is she “trashy”? If a boy has sex, is he “just being a boy”?

- **Beliefs:** For example, what does the target audience believe about condoms? That they have holes that let sperm and HIV through? That nothing's guaranteed 100%, so why bother? That condoms ruin the fun? That they reduce pleasure and spontaneity? What do they believe about sexual activity? That they are committing a sin if they have sex before they marry? That having a baby shows you're a grownup? That "having sex" means penetrative penile-vaginal intercourse, but doesn't include other sexual activities?
- **Behaviors:** What behaviors result from the target audience's knowledge, skills, attitudes, and beliefs? How many of them are already using condoms consistently and correctly? How many have tried condoms? How many have never used condoms? How many are abstaining from sexual activity? How many practice serial monogamy?

Epidemiologic and demographic information are generally available from the local or state health department — but you should be prepared to gather data at the community level. Much of the available information may not be broken down into small enough units — by block, or census tract, or zip code, for example — to really give you a detailed picture of your target audience.

Information about a target audience's psychographic profile, media habits and other lifestyle factors, and their knowledge, attitudes, beliefs, and behaviors can be found in databases managed by Arbitron, The Roper Center/Institute for Social Inquiry, Mediamark Research, Inc. (MRI), Simmons Market Research Bureau (SMRB), and Yankelovich Partners, Inc., among others. These databases and other information are available in many public and university library research sections, through university marketing departments, and through most advertising agencies. In addition, often the major daily newspaper or radio and TV stations will have detailed data on demographic and psychographic character-

istics of the community, usually available through their advertising department and supplied to potential advertisers. Local and state governments and the U.S. Census Bureau and Government Printing Office are other potential sources of information. Program planners can enhance existing information through surveys, focus groups, research studies, or other means.

Four Models of Understanding Human Behavior – Highlights

Prevention marketing is about understanding the target audience's behavior — what motivates it, changes it, and sustains it, what the barriers and facilitators are to healthy behaviors, and so on — and developing programs that influence those behaviors. Since the beginning of the AIDS epidemic, four behavioral models have been most often used to discuss HIV-related behavior: the *health belief model*, *social learning theory*, the *theory of reasoned action*, and the *transtheoretical model*. These models have common elements, as you'll see in the brief descriptions below. PMI is based predominantly on social learning theory and the transtheoretical model.

The Health Belief Model assumes that people's health behaviors are caused by four key health beliefs:

- perceived personal susceptibility or vulnerability;
- perceived severity of the condition;
- perceived efficacy of the behavior in dealing with the condition; and
- perceived barriers to the behavior.

For example, a young woman, Kimba, might not perceive herself to be at risk for HIV infection because she doesn't have penetrative intercourse and she and her friends, includ-

ing her boyfriend, aren't "the type" to be HIV positive. Kimba feels AIDS is a terrible disease and would not want to have it. She feels her behavior — not having penetrative intercourse — is an effective strategy for preventing HIV infection. However, her boyfriend, Martin, is pressuring her to have penetrative intercourse and indicates he may find another girlfriend if she doesn't, and, besides, many of her friends have said they are sexually active and engage in penetrative intercourse.

These four beliefs, combined with other characteristics like Kimba's gender, age, culture, etc., together create a *readiness to act*. In this case, the action she might take — without a prevention program to intervene — might well be to have unprotected penetrative intercourse with Martin. In developing an intervention, program planners would need to know things such as which of the four factors has the most effect on her behavior and which is most likely to change. For example, programmers wouldn't want to spend a lot of time and energy seeking to convince Kimba that AIDS is a terrible disease. She already believes that. They wouldn't want to try to convince her that avoiding penetrative intercourse isn't effective in preventing infection, because it is. Instead, they might want to focus on addressing her perceptions of her ability to talk to Martin about their risks in having penetrative intercourse (perceived personal susceptibility or vulnerability).

Social Learning Theory asserts that two elements strongly affect health behavior: outcome expectations and self-efficacy. If a person believes that a behavior will lead to positive consequences, and those positive consequences outweigh any possible negative consequences, he or she is more likely to adopt and sustain the behavior. Self-efficacy is the individual's belief that he or she can actually perform the behavior.

Using Kimba as an example, if she believes that persisting in having only nonpenetrative sex will result in Martin leaving

her, she may be unwilling to maintain that behavior. Even if she is committed to it, she may not feel able to communicate that effectively to him. An intervention might focus on peers role-modeling communication about nonpenetrative intercourse, having Kimba role-play the communication, and/or attempting to reduce the perceived negative consequence of Martin leaving. PMI used social learning theory in working with Linda Ellerbee's Lucky Duck Productions on "SMART SEX." The young people in the show role-model successful HIV prevention behaviors (self-efficacy) and discuss the outcomes. For example, one young woman says, "What do I say to a guy who won't use a condom? Goodbye!"

The Theory of Reasoned Action says that changing behavior results from changing how people think about it. Because behavior results from beliefs, attitudes, and intentions — all thought processes — the task is to change those elements. For example, Kimba's behavior is a result of her intention ("that is what I intend to do to keep safe") her attitude ("I feel good about this — it keeps me safe from HIV, STDs, and pregnancy"), ("I am worried about this; it may mean that Martin will leave me for someone else") her fear, and a perceived social factor ("my friends are all doing it").

Underlying Kimba's attitude toward her current behavior is a set of beliefs about the outcomes of continuing and discontinuing the behavior and how she feels about those outcomes. (For example, "Martin will leave me if I insist on this. But I've seen other people stick by their decisions. Sometimes their boyfriend or girlfriend left, sometimes not. I could make it without Martin. And besides, he's going into the Army right after we graduate. I might never see him again anyway.")

Underlying the social factor is the set of perceptions Kimba has about particular individuals or groups and how they feel about the behavior (for example, "Martin wants to have 'real sex' and he's angry that I keep saying no. Mom and Dad

would be so disappointed if they knew I was having sex before I got married. My friends think I'm so old-fashioned. Everybody's doing it." And so on).

An intervention based on the theory of reasoned action could address Kimba's attitudes or her perceptions of the norm, depending on what was revealed about these elements during formative research. It might seek to help her feel more positive about her choice of nonpenetrative sex; it might seek to reduce her perceptions of the negative consequences of the behavior; it might seek to convince her that everybody isn't having penetrative sex; it might seek to increase her desire to comply with her parents' wishes.

The **Transtheoretical Model** draws from various other models of behavior, thus its name. It is commonly called the "Stages of Change Model," because it assumes that behavior change is a series of steps. People begin with no intention to change (precontemplation); begin thinking about change (contemplation); their intent to change strengthens (ready-for-action); they try the behavior, usually inconsistently at first, and assess the outcomes; and then move toward consistency if the outcome is favorable (action). Finally, they adopt the behavior as a routine part of their lives (maintenance or sustained change).

Various factors influence a person's movement through these stages, including knowledge, attitudes, and beliefs. For example, Kimba is contemplating changing her sexual behavior with Martin. Several things could move her forward or backward on the continuum. For example, Martin could continue to pressure her, and she could move to the ready-for-action stage. She might even try penetrative intercourse with him. If she found she did not like the consequences of that action (for example, she felt unsafe or she felt she let her parents down), she might return all the way to the precontemplation stage, and have no intention to change.

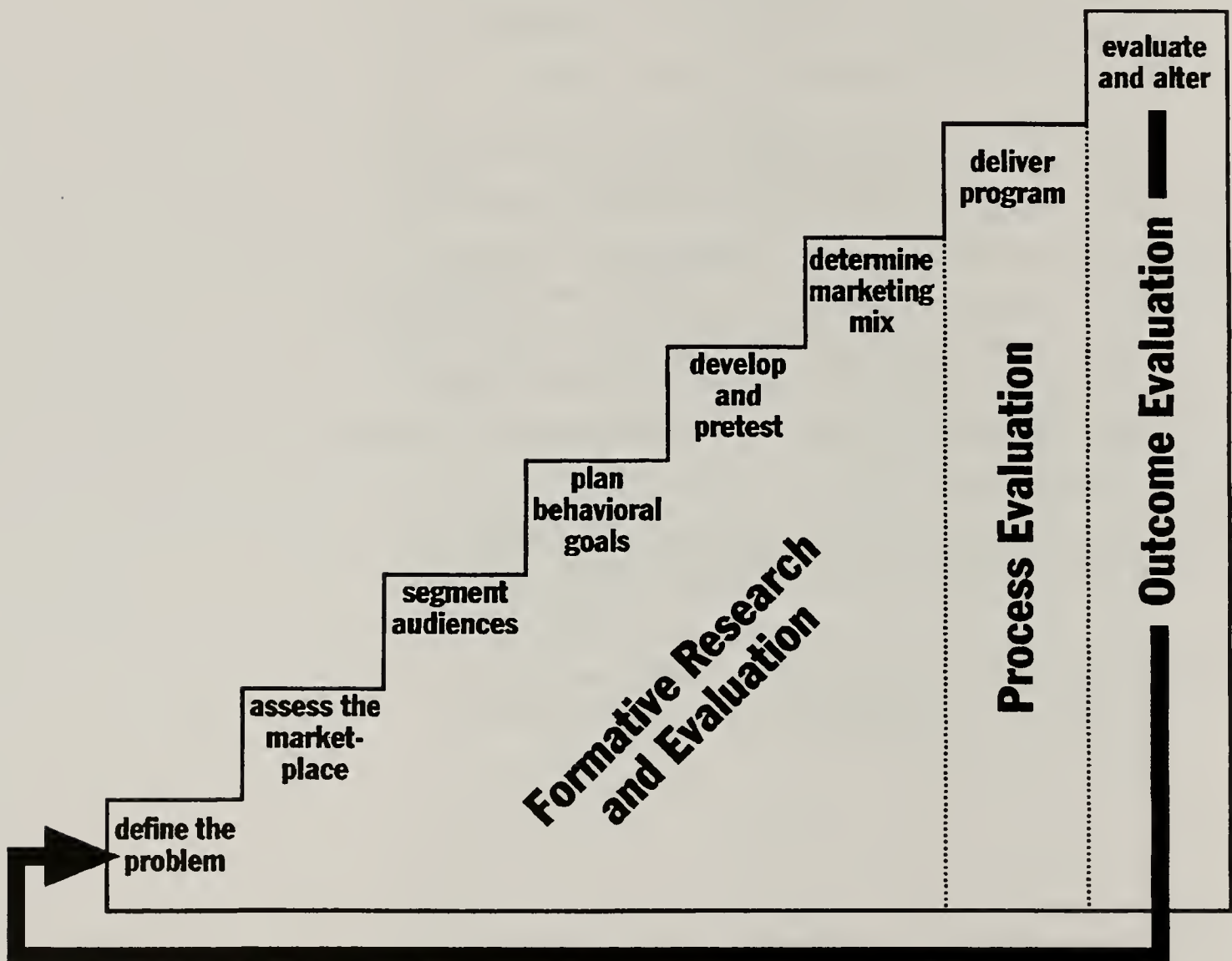
Interventions based on this model typically seek to move people from one stage to the next. For example, an intervention for people in the precontemplation stage might seek to increase their awareness of HIV/AIDS, their sense of personal vulnerability, and their knowledge about effective personal strategies for avoiding HIV infection. Unfortunately, this is where many, many prevention programs (not just about HIV) begin and end.

People in the contemplation stage might be moved to the next stage by increasing their skills in communicating with partners about sexual activities. Once in the ready-for-action stage, an intervention might address perceived consequences of asking a steady sexual partner to use a condom. An intervention in the action stage might address barriers to consistent condom use by ensuring that condoms are readily available to the target audience in the place(s) they might have sex. And an intervention in the maintenance stage might address the complex feelings of people who are HIV negative whose partners are HIV positive and the difficulties in continuing to practice safer sex. As you can see, the stages of change model is a framework that readily adapts to elements from all the other models.

For more information about how prevention programs can use behavioral theory, see "Structuring HIV Prevention Service Delivery Systems on the Basis of Social Science Theory," by Valdiserri, West, Moore, Darrow, and Hinman in the *Journal of Community Health* vol. 17(1992):259-69.

Social Marketing Is A Series of Steps

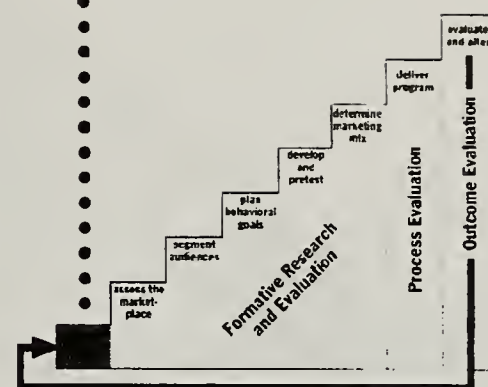
Social marketing programs can be divided into a series of sequenced steps, each reinforcing and expanding the other. Information gathered during one step can influence a previous step. For example, data gathered as you segment audiences may cause you to revisit your definition of the problem, or you may change your marketplace assessment as you determine gaps.



Define the Problem

At the heart of the HIV problem you will always find human behavior. Epidemiology helps pinpoint who's at risk and what they do that puts them at risk. But it isn't the whole story.

Epidemiology doesn't give program planners the necessary insight into a target audience's perspectives on behaviors, especially the causes or "determinants" of behaviors: external factors like poverty and isolation from services, and internal factors like perceptions of self-efficacy (the individual's belief that he or she can do the desired behavior), social norms, barriers to performing lifesaving behaviors, and benefits of adopting lifesaving behaviors. This information is critical to understanding how an audience sees and reacts to a specific behavior you want to promote. To get it, you need behavioral science for insights into the target audience's current knowledge/skills, attitudes, beliefs, and behaviors, and marketing data about consumers' buying behaviors and the external and internal forces that prompt them.

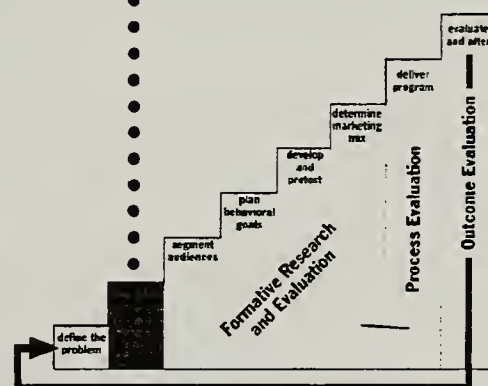


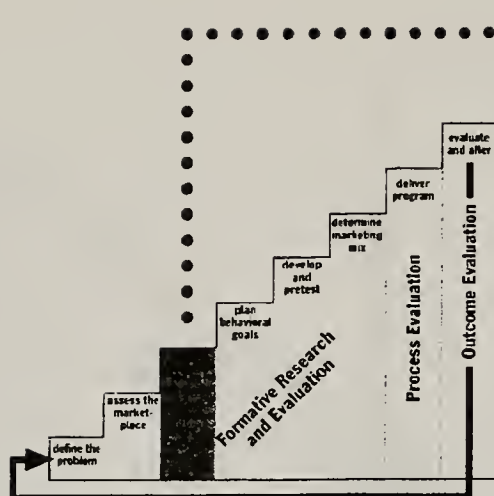
Assess the Marketplace

This stage is commonly called needs assessment. It includes "environmental scanning" to get a picture of the community in which you will be working: its politics, its consumers and their habits (what they buy, what they do for fun, etc.), what its media have reported on, and other characteristics. During this step, program planners should:

- identify and consult with relevant community groups;
- analyze what they know about the audience and what they need to know to design an audience-centered prevention program;
- assess local HIV prevention programs — Who do programs serve? What are their services? What are the gaps in service? What resources are available to address those gaps?

For more information on this step, see recommendations from the Prevention Collaborative, pages 37–47.



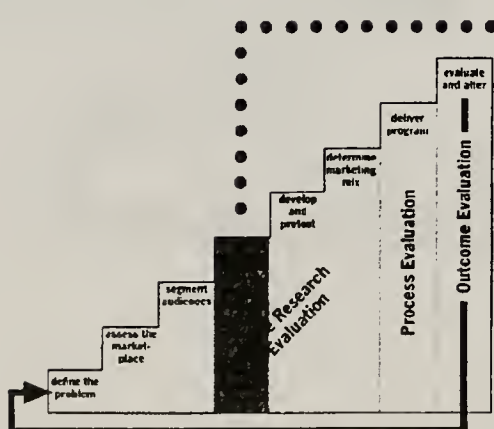


Segment Audiences

Demographics are an obvious way to define groups — for example, along racial/ethnic lines, by sexual activity, or by gender, or by age. But demographics don't provide the whole picture of a given audience. Within communities, within age groups, within sexes, within socioeconomic rungs, different people share different values, are affected by different pressures, and receive information through different channels. Social marketing defines groups according to these various lifestyle factors, and spotlights likenesses and dissimilarities within and across groups. For example, even across race, ethnicity, sexual orientation, and socioeconomic status, research shows that young adults 18-25 are more alike than they are dissimilar. It makes sense to create messages that capitalize on that similarity.

But even people who share lifestyle factors may be at different levels of readiness for new behaviors. In a single peer group, one teenager might be committed to abstaining from sex, another might be sexually active but willing to try condoms, another might reject the idea that he or she is at risk for sexually transmitted diseases, including HIV infection. Behavioral science helps program planners determine which perceptions, attitudes, and beliefs are important to specific audiences.

For strategies on this step from the Prevention Collaborative, see pages 57-47.



Plan a Program With Specific Behavioral Goals

Armed with extensive audience research, social marketers define audience segments and set measurable, realistic, and prioritized goals for each segment. Proposed interventions aim to influence specific beliefs, increase specific skills and knowledge, and to change or maintain specific behaviors.

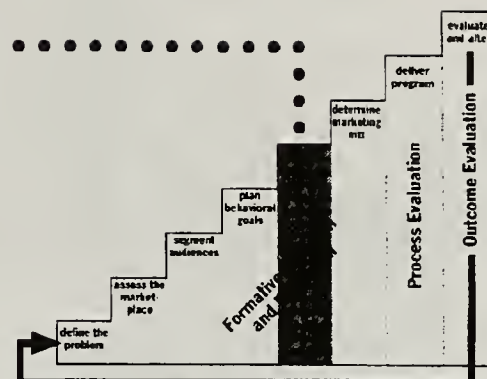
The program plan should outline specific strategies and methods for delivering messages and an evaluation plan that

includes both process and outcome measures to monitor the impact of your messages.

See pages 37–47 for more information.

Develop and Pretest Strategies and Materials

Design and test strategies and materials for effectiveness — delivery effectiveness, communication effectiveness, effectiveness in influencing audience behaviors. Adapt strategies and materials based on audience feedback. See pages 38–39 and 42 for more information.



Behavioral Model

Social marketing focuses on the audience's behavior and, just as important, the determinants of that behavior.

Behavioral Model

$$\begin{array}{c} \text{External} \\ \text{Determinants} \\ \text{of Behavior} \end{array} + \begin{array}{c} \text{Internal} \\ \text{Determinants} \\ \text{of Behavior} \end{array} > \begin{array}{c} \text{Behavior} \\ \text{to be} \\ \text{Influenced} \end{array} > \begin{array}{c} \text{Health} \\ \text{Outcomes} \end{array}$$

External determinants of behavior are forces outside the individual that affect his or her behavior — for example, the availability of condoms or whether sexuality education programs are required for all students in high school. Internal determinants of behavior are the forces inside the individual that affect his or her perception of a behavior — for example, the perception that only “loose” girls carry condoms or the belief that condoms aren’t “cool.”

These two factors vary in importance from one audience and behavior to another. The focus of audience research is to identify the *targets of opportunity*: the determinants that are *both* important and possible to affect with available resources.

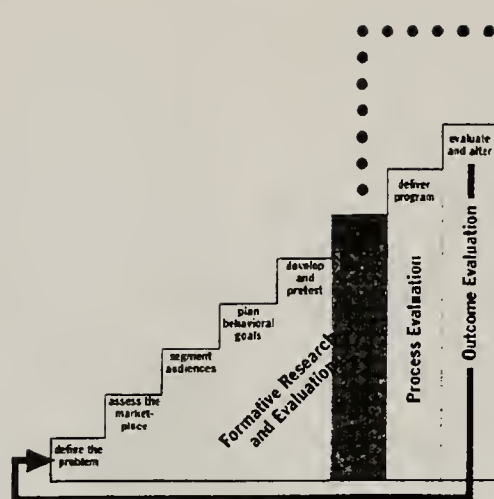
For example, community-based program planners may choose to concentrate on improving and extending available services rather than on a broad social issue that influences individual behavior, such as poverty; or on enhancing target audience members’ self-efficacy (the individual’s belief that he or she can do the desired behavior) rather than seeking to change broad social norms, such as American adults’ notions about adolescent sexuality. At the community level, focused programs and messages to induce personal change — such as increasing people’s skills in talking to partners about using condoms, thus enhancing their beliefs that they can perform such behaviors — are more likely to be effective than diffused programs to engineer social change, such as ending poverty.

External Determinants

- Epidemiology
- Demographics
- Services
- Policy
- Culture
- Consequences

Internal Determinants

- Knowledge
- Perceived risk
- Attitude
- Perceived consequences
- Self-efficacy
- Perceived social norms
- Intentions



..... Determine the Marketing Mix

A program's marketing mix — or the “4 Ps” of product, price, promotion, and place — is central to its success. These four elements balance the audience's perceptions and feelings about a given health behavior to create optimum appeal. This is where formative research with the target audience is invaluable, because that research reveals what the audience believes about your product, what they are willing to do (or not do) to get your product, how you can best position the product to appeal to them, where they can get the product and how, and so forth. For more information on formative research, see page 42.

Product

In commercial marketing, “product” usually means a thing to sell to consumers — an item, a service, sometimes an idea. In social marketing, the product is typically the desired attitude or behavior that will be exchanged for another attitude or behavior. To be successful, a product must offer a benefit people want. For example, tartar control cat food “offers” better pet breath. What does safer sex “offer” that people want — and want enough to exchange unsafe sex for?

Price

The old saying, “Everything has its price,” couldn't be more true in social marketing. But the price usually isn't merely the actual monetary cost. In this context, the price is the monetary, physical, and/or emotional cost-to the consumer to buy the product. The highest costs are often social, psychological, or emotional. For example, research with people at high risk for HIV infection often reveals they fear losing their partner if they insist on using condoms — a high, and seemingly unaffordable, cost to them.

Prevention program planners must understand and appreciate the costs their targeted audiences will pay in exchanging behaviors. At the very least, it is essential to know that changing behavior is seldom, if ever, easy. And

difficulties are increased monumentally when people's self-esteem, safety, comfort, and other central ego supports are involved. This is compounded when they don't get immediate benefits they care about after paying what to them may be very high costs.

Appreciating how consumers perceive costs helps you identify a desired behavior that has benefits that make the costs worth it. Only then can you position the desired behavior and its benefits and realistically ask people to change.

It's important to remember that messages may not center on lowering the cost, but on increasing the value of the product. For example, your audience might appreciate the benefits of latex condom use (protection from HIV and other STDs, peace of mind, greater staying power, etc.), making the costs of using condoms (loss of skin-to-skin contact, loss of sensation, or perceived lack of spontaneity, etc.) seem reasonable and affordable. Or they might value the benefits of complete abstinence (no need to worry about diseases or pregnancy, feeling good about being an individual and not going along with the crowd, knowing your partner cares for you and not just for sex), making the costs of abstaining (such as being perceived as a prude, not being like your peers, forgoing pleasure, losing love) seem less consequential.

Promotion

Promotion is about messages and the channels that deliver them. A comprehensive promotion plan takes into consideration the full range of communications tools — such as social advertising, public and media relations, media advocacy, entertainment media, personal selling, community-based programs, direct marketing, special events, and live entertainment. Messages should be clear, break through the clutter of other messages, be memorable, persuasive, accurate, and widely recognized. Promotion is

Promotion Evolves

As prevention programs have become more sophisticated in reaching target audiences and as target audiences' attitudes have changed, promotions have evolved.

■ *The Stop AIDS program in San Francisco works to change or support **social norms** with pre-existing groups (PEGs) such as athletic leagues, service clubs, and choirs to promote safer sex discussions. This allows the PEGs project to reach a large number of people with a minimum of contacts and has the benefit of encouraging group members to support one another in safer sex behaviors. Program coordinators warn this approach can be time-consuming and that it requires gaining the buy-in of key group members. Results, however, are worth the extra effort. Stop AIDS is a Prevention Collaborative member. Telephone: 415/575-1545.*

■ *CDC's Center for Prevention Services' AIDS Community Demonstration Projects targeted members of populations at high risk for HIV infection, including injecting drug users (IDUs) not in treatment, female sex partners of IDUs, women who trade sex for money or drugs, men who have sex with men (MSM), and youth at high risk. Demonstration site cities were Dallas, Denver, Long Beach, New York, and Seattle. Among the interventions used were **small media role-model stories** on baseball cards, flyers, and brochures. These featured an authentic story about a person in the targeted community, told in the person's own language, developed from interviews with community members. These small media interventions described the (cont.)*

person's stimulus and/or motivation for initiating or considering a behavior change, the type of behavior begun, how barriers to change were overcome, and the reinforcing consequences of the change. Message selection was guided by data and information from the targeted community and refined by focus group research and evaluation.

■ *Dismayed over Washington, DC, transit ads disparaging condoms, Whitman-Walker Clinic, AIDS National Interfaith Network, National Association of People With AIDS, National Minority AIDS Council, and Metro TeenAIDS used media advocacy to advance their position. They held a press conference and focused on the irrefutable scientific evidence that latex condoms are highly effective in preventing HIV infection. Press coverage included all three local network TV affiliates, the local independent television station, radio, and the Washington Post, as well as gay and ethnic print media coverage in Florida, San Francisco, and other towns across the country, all delivering the message: "Condoms work!"*

■ *AIDS educator Pedro Zamora used an entertainment show on MTV to promote safer sex. MTV also carried "SMART SEX," developed by producer Linda Ellerbee with assistance from CDC, which followed the lives of young people in communities across the U.S., offering a behind-the-scenes look at their sexual choices. "Reality Bites," a feature-length film about Generation X, carried one of the Prevention Marketing Initiative PSAs on its video rental version.*

designed to prompt a decision to practice the target behavior. That decision is then acted on in various places.

Again, the consumer's needs, lifestyle, and other factors must take precedence. Just because board members, program planners, or others may be personally influenced by editorial coverage in newspapers and magazines doesn't mean that consumers will be. The targeted audience may not regularly read newspapers or magazines. Or if they do, they may not find these sources of information to be credible.

Place

In commercial marketing, "place" refers to the location a product is offered. The optimal place is the most convenient outlet to consumers that is *also* the outlet that offers the most emotional benefits. For example, a product (perfume) with a high price (\$65 an ounce) could be placed in a variety of retail locations ranging from discount stores to department stores. Discount stores would likely be the most convenient place for potential consumers. But would they offer consumers an emotional benefit? Consumer research would probably show that people would not expect to purchase expensive perfume in those locations and would not want to think of themselves as discount shoppers for this item. On the other hand, large department stores might be less convenient to get to, but shoppers would be more likely to expect to purchase a high-ticket item in them and consumers would feel good buying in such stores. In social marketing, when the product is usually a behavior, the analysis of convenience and emotional benefits is equally important, but the goals are different. Analyzing place is really analyzing the locational constraints on behavior. It takes into account that people may have made a previous decision — for example, to say no to sex or to always practice safer sex — and then examines how a particular place, such as a bar,

might affect that previously made decision. The analysis asks, "What can I do to make the place where people act on their decisions more likely to prompt the target behavior?"

A key question to ask in thinking about place is: What has the audience told us about this? Where do the consumers spend the majority of their time? Or, what various "lifepoints" — school, stores, restaurants, shelters, public restrooms, etc. — do they cross daily? Do you know how these locations affect their behavior? Sometimes, there is relatively little that can be done to make a place more likely to elicit the desired behavior. But other times your creative analysis of place will pinpoint some avenues for change.

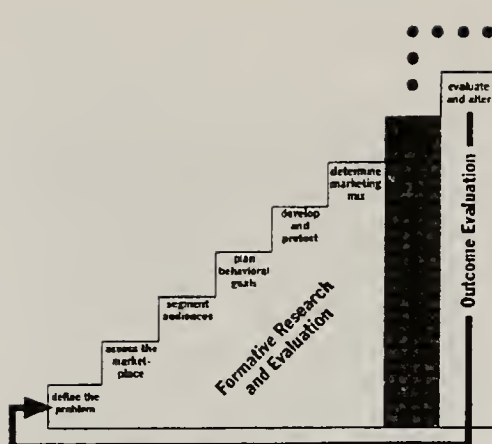
Analyzing Place as a Catalyst for Behavior Change

The target behavior → negotiating safer sex

Where do people act on the decision to practice this behavior? → bars, home, streets, etc.

Can I change where people act on the decision? → no — not likely to change

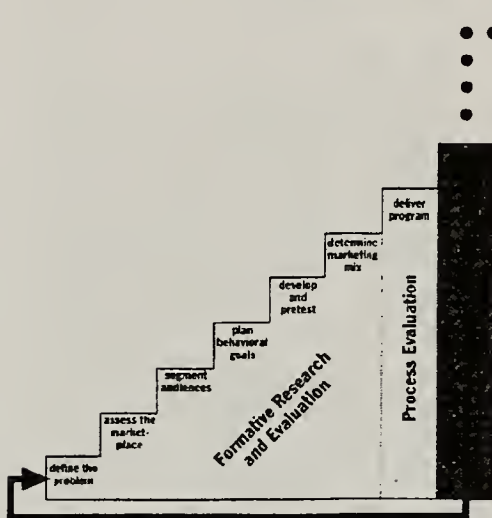
What can I do to make one or more of those places more conducive to the target behavior? → make negotiating safer sex more **convenient** by having condoms free and available; increase **emotional benefit** by having safer sex posters displayed, giving safer sex promotional items (such as buttons, hats, etc.) to bartenders and other staff, and holding safer sex special events, so that patrons know the location as a safer sex place and think of themselves as safer sex practitioners because they go there.



..... Deliver the Program

Put the program to work with the target audience. Distribute materials and messages, and generate support. Ensure all linked agencies — community-based organizations, AIDS service organizations, schools, etc. — work together to reinforce the program and its behavioral goals.

For strategies, see pages 49–54.



..... Evaluate and Alter As Needed

Monitor the program. Change strategies, messages, materials, and channels as necessary to meet evolving needs. Social marketing programs are not unchanging, static programs. They change as audiences change — constantly!

Evaluate the total program. Use both process criteria and outcome criteria. How many people did you reach? Who did you reach? When? Where? How often? Who responded? How? What changes occurred?

Based on what you learn, ask: “What do we need to change to move closer to our program goals?”

For evaluation guidelines from the Prevention Collaborative, see pages 37–47.

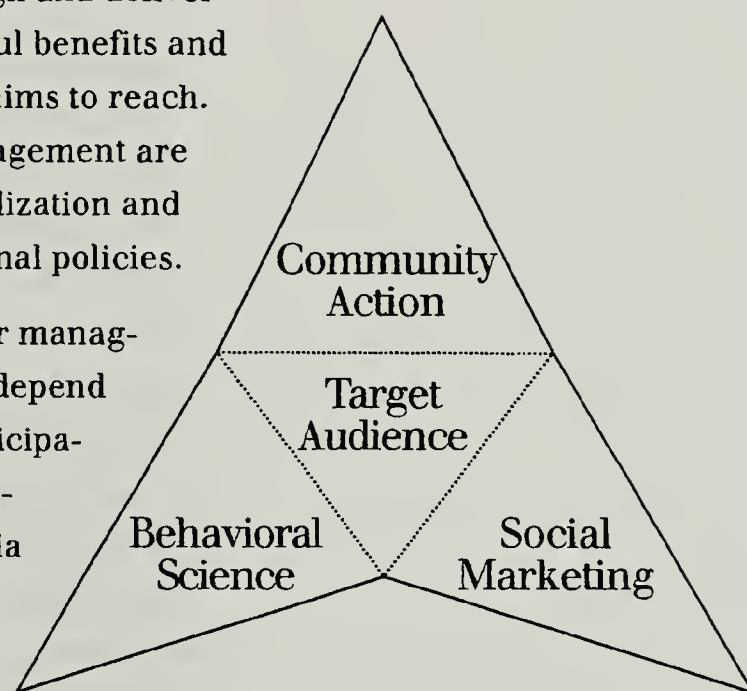
Community Action: An Integrated Framework

Social marketing is most effective when it draws upon various skills and resources — audience research, behavioral science, creative media and message development, innovative methods and places of delivery — to design and deliver HIV prevention programs that offer meaningful benefits and reduced barriers for the people the program aims to reach. These technical tools and their strategic management are best complemented by solid community mobilization and services, as well as supportive state and national policies.

Even if a single organization is responsible for managing a social marketing program, success will depend on the combined resources, support, and participation of many groups, including the target audience themselves. Support from the mass media can multiply the diffusion of messages manyfold. Policymakers can focus public attention on program issues. Credible community spokespeople, business and religious leaders, school staff, and board members can sanction public discussion.

The community has a vital stake in HIV prevention. And because HIV prevention is tied so directly to volatile emotional issues — among them sexuality; sexual identity; drug use; poverty; people's religious, moral, and ethical beliefs and behaviors — prevention program staff must take the prevailing attitudes in the community into consideration.

Clearly, HIV prevention programs must be driven by science — the sciences of epidemiology, human behavior, communications. But science alone will not guarantee success if large



segments of the community oppose or don't actively support a program or an intervention.

Prevention messages work best when the target audience gets them with the least amount of “noise” impeding their reception. Think of it like static on the radio. Lack of community consensus can lead to opposition or confusion as well as disintegrated and competing efforts — all of which will be sources of static cluttering the airwaves. Early in planning, prevention program developers must strive to integrate the various voices in their community to make the prevention message stronger and clearer and to reduce static that can break up the message. If you see opposition on the horizon, think strategically about what you can do to reduce it or at least to minimize the “noise” it may generate. Strategies are varied. For example, ask those who support you to put their support into action at community meetings, to write letters of support, to give positive interviews to local media, etc. Consider the opposition's vulnerabilities — do they lack knowledge about your target audience's risky behaviors and the determinants of those behaviors? Do they have experience with successful prevention programs? What are their concerns — could they be valid? This kind of analysis is often called “force field analysis,” because it examines the forces that enhance or inhibit a course of action. Analyze the forces in your community to determine where you need to concentrate your pre-intervention efforts to position your program best.

Community action, coalition building, and collaboration are essential to successful prevention programs. This is why CDC's brand of social marketing — prevention marketing — includes community action as one of three equal elements. For guidelines from the Prevention Collaborative on this topic, see pages 55–62. For a list of questions to guide your thinking about applying prevention marketing to community-level interventions, see Appendix F.

Guidelines for Community-Based Prevention Marketing Programs

Overview of Resources

This section features recommendations from the Prevention Collaborative for prevention program staff. It also includes resources for more information and assistance. Included are guidelines in five key program areas:

- research and evaluation (see pages 37–47);
- linkage and integration with existing health, education, and social services agencies (see pages 49–54);
- coalition building (see pages 55–62);
- health communications (see pages 63–73); and
- community implementation (see pages 75–80).

Clearly, these topics are not totally distinct from one another. Linkages are part of successful coalition building; research and evaluation are cornerstones of effective health commu-

Program Examples

■ *The Healthy Neighborhoods Coalition in Hampton, Virginia, focuses on building communities of care for children and families. The project works to gain a greater voice for youth in the community in three key ways: training youth and adults to work together, placing youth in advisory and decision-making roles in local organizations, and providing opportunities for youth input in community decisions.*

■ *In San Francisco, the Mayor's Youth Forum brings young people — most of them with at-risk backgrounds — to participate in the city government process. The young people identify issues — such as violence prevention, education reform, and women's rights — and work in community organizing and advocacy projects. The program is supported by the U.S. Department of Health and Human Services.*

■ *The HIV Center for Clinical and Behavioral Studies in New York City sponsors weekly meetings about topics in HIV prevention. One month's schedule included a meeting on gender differences among university students in preventing risky sexual practices and HIV-related risk behaviors; another examined homelessness, chronic mental illness, and HIV and women. Contact graduate departments of anthropology, psychology, public health, or social sciences in your area to find out about similar efforts or projects that might relate to your HIV prevention efforts.*

nications. Topics overlap because prevention marketing is an integrated approach to program design, delivery, and evaluation. The guidelines can be viewed as the backdrop for successfully implementing the prevention marketing steps outlined in the previous section.

Several overarching themes emerged as the Prevention Collaborative, the Guidelines Working Group, and the Resource Working Group worked to develop this document. These common elements are highlighted here to emphasize their importance to all prevention marketing efforts.

Involve the target audience in program conception, research, design, decision-making, implementation, and evaluation.

Involving the target audience helps shape each phase of any intervention and gives program planners a realistic perspective on the issues relevant to the program's consumers. This is especially important since formative research funding may be slim. A word of caution, however: Involving some members of the target audience should not replace formative research, because the information you get from that small group may be biased and cannot be generalized to the larger group. For more information, see the resources on page 42.

Design programs with cultural competence.

Cultural competence can be defined as cultural sensitivity combined with the ability to intervene successfully in a specific population. Cultural components to weigh include characteristics like race/ethnicity, gender, sexual orientation, age, education level, religion, activities, and so on. Don't stop at the obvious. For example, among injecting drug users, the culture of speed shooters is different from the culture of heroin users. Ask yourself: "What is it that distinguishes this particular group from others?" The answers you come up with are likely

to be key cultural components to consider. Involving the target audience is a sure-fire way to monitor the cultural competence of your intervention. Sometimes a target audience may have a standard of behavior that is at odds with the program's desired behavior. For example, if the norm within a group of young people is multiple sex partners, efforts to promote abstinence or decrease sexual partners will run counter to the prevailing norm and will likely be considered unacceptable, at least initially. A short-term culturally competent approach would seek to find an acceptable prevention alternative (such as condom use) that does not restrict the prevailing behavior, but does offer an acceptable degree of protection. Changing the group's norm may ultimately be accomplished *more quickly* with this kind of approach than if you had attempted to force a culturally unacceptable solution on the group.

Establish partnerships at the local, state, and/or national level.

Partnerships have the potential to enhance the efforts of all collaborating parties. Combining resources and expertise allows for greater reach, broader understanding of diverse constituencies, and more sustainable impact. Partnerships for HIV prevention should go beyond the typical boundaries to include alliances with varied organizations, among them private enterprise, religious groups, sports and arts organizations, and others.

Share information about HIV prevention programs and disseminate results of program evaluations.

A common concern among prevention program staff is that, as we move further into the second decade of the AIDS epidemic, there is still confusion and lack of knowledge about *what works*. Sharing information about program

evaluations and the results of research is vital to take advantage of lessons learned, to stop reinventing the wheel — and to make prevention more effective and efficient. Local networking is strongly encouraged, and should be part of each CBO's approach to community intervention. CBOs should make every effort to coordinate with their local HIV Prevention Community Planning groups. One vehicle for sharing information nationally is the Prevention Collaborative; for more information, call 404/639-0956 or leave a message toll-free, 24 hours a day by phoning 800/427-4784, then dialing 329-1659 to reach the Prevention Collaborative Liaison. Another vehicle is CDC's National AIDS Clearinghouse, a storehouse of information. NAC's toll-free number is 1-800-458-5231.

Resources for Working with Young Adults

Advocates for Youth has fact sheets and bibliographies on a wide range of adolescent sexuality issues, information and a curriculum on peer education (Teens for AIDS Prevention [TAP]), and a national clearinghouse on school-based condom availability programs. For more information, contact Jennifer Hincks Reynolds at 202/347-5700 (phone) or 202/347-2263 (fax); 1025 Vermont Ave., NW, Suite 200, Washington, DC 20005. Advocates for Youth is a Prevention Collaborative member.

The Center for AIDS Education and Training, a Prevention Collaborative member, offers custom-designed HIV prevention programs, curricula, and training sessions for youth and adults as well as technical assistance in planning and developing HIV prevention and education efforts for youth. Contact Nancy Evans, 415/346-8316 (phone) and 415/928-1426 (fax); 1675 California St., San Francisco, CA 94109.

Center for Sexual Health, Planned Parenthood Federation of America, Inc., 810 Seventh Ave., New York 10019; 212/261-4628 (phone) and 212/247-6269 (fax). Offers information on HIV testing and counseling as well as sexual health for adolescents and adults. PPFA is a Prevention Collaborative member.

The Center for Youth Development and Policy Research. Working with the University of Michigan, the Center is conducting exploratory research in the fields of youth participation and neighborhood development. The project intends to identify ways in which young people can participate more actively in neighborhood development and to assess the forces that promote or limit youth involvement. Call 202/884-8267.

Community Partnerships with Youth, Inc. CPY is a national training and development center for youth and youth professionals. CPY designs training curricula, offers specialized training in trusteeship and governance, and provides technical assistance to youth-serving organizations and schools in the areas of youth empowerment, community service, service-learning, and adult-youth relationships. Call 219/422-6493.

ETR and Associates provides educational publications, training, and research services in HIV prevention, pregnancy prevention, and health education programs. They have a catalog of approximately 600 titles, including books, pamphlets, videos, and curricula, such as *The HIV Challenge: Prevention Education for Young People*. Contact Julie Taylor, 408/438-4060 or 800/321-4207 (phone) or 408/438-3618 (fax), P.O. Box 1830, Santa Cruz, CA 95061-1830.

Metro Teen AIDS has a how-to guide for youth and youth advocates who want to recommend, improve, and evaluate HIV counseling and testing services for adolescents. For more information, call 202/543-9355. Metro Teen AIDS is a Prevention Collaborative member.

The National Advocacy Coalition on Youth and Sexual Orientation provides information and expertise on local and national public policy issues affecting gay, lesbian, bisexual, and transgender youth. NACYSO is sponsored by New York's Hetrick-Martin Institute and is a Prevention Collaborative member. For more information contact 202/783-4165 ext. 49 (phone) or 202/347-2263 (fax) or nacyso@aol.com (email); 1025 Vermont Ave. NW, Suite 200, Washington, DC 20005.

National Network for Runaway and Youth Services. The National Network works to ensure that youth in high-risk situations can be safe and grow up to lead healthy and productive lives. The National Network actively engages in public education efforts, promotes youth/adult partnerships, and strives to strengthen staff and community-based organization capacity to provide effective programs and services to youth in high-risk situations. Training and technical assistance is provided in a variety of areas, including the professional development of youth workers, youth leadership, peer education, HIV/AIDS and substance abuse prevention, grant writing, and community and youth development. The National Network is a membership organization that represents over 1,200 constituents, primarily community-based youth-serving agencies. The National Network is a Prevention Collaborative member. Call 202/783-7949.

National Parent and Teacher Association, a Prevention Collaborative member, has information on parents' roles in HIV prevention, resources for establishing community education events, and how-to materials for discussing HIV/AIDS with children and teens. *How to Talk to Your Teens and Children about AIDS* is a brochure for parents that presents HIV/AIDS facts, guidelines for discussion, and recommendations for further reading. *Como Hablar con Sus Adolescentes y Niños Del VIH/SIDA* is the Spanish-language version. *HIV/AIDS Education Planning Guide for PTA Leaders* presents the basic facts on HIV/AIDS and guidelines for the development of community-based HIV/AIDS awareness programs; re-

sources are included. Two more brochures, *Talking to Your Child About Sex* and *Talking to Your Teen About Sex*, outline the approach parents can take to have successful discussions with children and young people. Contact Claudia Soldano, HIV Prevention and Education Project Coordinator, or Victoria Duran, Health and Welfare Program Manager, 312/670-6782 (phone) or 312/670-6783 (fax).

National School Boards Association has information and sample policies related to HIV/AIDS to support research and program development for community-based HIV prevention programs involving and/or affecting schools and school-aged children and young people. Contact Brenda Z. Greene, 703/838-6756 (phone), 707/683-7590 (fax), bgreene@tmn.com (email); 1680 Duke St., Alexandria, VA 22314. NSBA is a Prevention Collaborative member.

Youth As Resources. YAR is a Washington, DC-based program that provides small grants to young people to design and carry out projects to meet community needs. With support and funding from local businesses, foundations, and social services agencies, a local board of youth and adults solicits, reviews, and funds proposals written by youth with adult assistance. Call the National Crime Prevention Council at 202/466-6272.

Resources for Partnership

The National AIDS Fund (formerly the National Community AIDS Partnership). The Fund was established by the Ford Foundation in 1987 to support communities by developing resources for HIV/AIDS prevention and care. The Fund has a "challenge grant program" that matches local funds with national dollars. Monies are distributed based on the decisions of local partners. Located in Washington, DC, the Fund currently supports 38 communities in 33 states. Paula Van Ness, the president of the Fund, describes the benefits of partnership

as extending beyond money: "Our community partnerships help shape and support the spectrum of HIV/AIDS care, services, and prevention programs through grant-making, public policy, and capacity-building efforts." The Fund is a Prevention Collaborative member. Call 202/408-4848.

The National Alliance of State and Territorial AIDS Directors. NASTAD members — directors of state and territorial AIDS prevention and service programs — can offer help in coordinating with local HIV Prevention Community Planning Groups. Located in Washington, DC, NASTAD is a Prevention Collaborative member. Call 202/434-8090. (For a complete listing of state and territorial AIDS directors, see pages 111–115.)

TIDES — Funders Concerned About AIDS is a New York-based association of 1,200 individual grant-making executives from foundations and corporations across the United States and in 12 other nations. FCAA was founded in 1987 to mobilize philanthropic leadership and strategic resources to eradicate the HIV/AIDS pandemic and to address its economic and social consequences. Call 212/573-5533.

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Research and Evaluation

Why Do Research and Evaluation?

Prevention Collaborative members note that research and evaluation can be intimidating to prevention program designers. This may be a result of negative experiences, a perceived lack of expertise, a belief that behavior change is difficult if not impossible to measure, or the notion that research and evaluation are time-consuming, expensive, and not cost-effective.

But research and evaluation are critical pieces of every program — not just programs based on social marketing — and are increasingly required by program funders from both the public and private sectors.

Research and evaluation are the paths to and from your target audience. Without them, you may well be far off the mark, squandering precious time, resources, and energy.

Research and evaluation don't have to be complex or complicated. Follow the suggestions from the Prevention Collaborative on the next few pages.

Four Key Evaluation Types

Prevention marketing programs rely on research and evaluation at several stages to ensure interventions are on target before widespread implementation, to identify elements that work and those that don't and need to be changed, and to pinpoint the changes that occurred in the target audience (short-term and long-term) as a result of the intervention.

Four key types of research and evaluation can be applied to prevention marketing programs: **formative, process, outcome, and impact.**

The purpose of **formative research** is to maximize the chances that your intervention will succeed *before you undertake any program activities*. Formative research, including a needs assessment and research into consumers' knowledge, skills, attitudes, beliefs, and behaviors, must be done before drafting any intervention. Later, it provides vital information on how to refine program design and implementation strategies before programs are implemented. As messages, materials, and strategies are proposed, they must be pretested with the target audience to assess their effectiveness.

According to *Making Health Communication Programs Work* (See Appendix D), pretesting helps fine-tune interventions by:

- **Assessing Comprehension**
- **Identifying Strong and Weak Points**
- **Determining Personal Relevance**
- **Gauging Sensitive or Controversial Elements.**

Pretesting is often accomplished through self-administered questionnaires, phone and intercept interviews (at malls, for example), focus groups, readability testing for written materials, theatre testing for audio or video materials, and gatekeeper reviews. For more information on formative research, see page 42.

As the program moves into the next stage — delivery — additional evaluation is needed. **Process evaluation** answers such questions as:

- What was done?
- To whom?
- By whom?
- To how many?
- How many times?

- For how long?
- How?
- When?
- Where?

Process evaluation tells you whether you are reaching the intended audience. It informs mid-course decisions, allowing you to correct small problems before they become big ones. It tells you about the most cost-effective and efficient way to implement your intervention.

Most prevention programs stop at process evaluation. But **outcome and impact evaluation** answer the most important question of all:

What changes happened as a result of the program?

Outcome evaluation documents short-term results of your intervention. It describes short-term quantitative results — for example, how many calls you received after a poster went up. It also describes qualitative results — such as attitudinal changes (the number of people who think delaying sexual activity with a new partner is a good idea); expressed behavioral intentions (“the next time I have sex, I’ll use a latex condom”); short-term behavior changes (condom purchases go up); knowledge changes (the percentage change in the number of people who know the effect of oil-based lubricants on latex condoms); and changes in social systems (such as decriminalizing the possession of needles or syringes without a prescription). Note that all these qualitative elements can be — and should be — expressed quantitatively. Based on formative research, program planners should be able to numerically describe percentage change, numbers of people expressing intentions, gains in knowledge, etc.

Evaluating outcomes is not easy. But it’s essential. Resources are available in most areas to help. Universities and colleges may be helpful, especially if the data are of interest to graduate students searching for a dissertation topic or to professors who want to publish. Local and state departments of health may also be able to help, or to steer you to consultants in your area.

Impact evaluation is the long-range assessment of your efforts. It provides information about changes in morbidity (disease) and mortality (death), long-term maintenance of the desired behavior, rates of unsafe behaviors, productivity lost or gained, economic increases or decreases, and so on. Impact evaluation involves long-term commitment. It can be costly. And it requires an understanding of all the forces affecting individual behavior, such as policies, government, and laws. For all these reasons, impact evaluation is typically not done for specific interventions. It is generally more comprehensive. Work with your local or state health department to assess whether impact evaluation is possible for your program.

Epidemiologic Definitions

Epidemiology is the study of health and disease distribution in populations. Epidemiology is the science that underlies the public health practice of disease prevention and control. Epidemiology defines disease by:

- **who** is affected; who is at greatest risk
- **what** the behaviors are that put people at risk; what the trends are
- **when** diseases occur
- **where** diseases occur
- **why** diseases occur
- **how** diseases occur

Incidence is the number of new cases of a disease or condition that occur within a given time — for example, the yearly incidence of HIV infections or of AIDS diagnoses. Incidence numbers give us a picture of current trends and suggest possibilities for future trends, if interventions do not interrupt their course.

Prevalence is the number of people living with a disease or condition during a given time — for example, the prevalence of AIDS cases or of people who are HIV+. AIDS and HIV prevalence numbers give us a picture of current and future health care and social service needs and populations where future HIV transmission risk could remain high.

Incidence and prevalence rates are the number of cases per a standard population size, usually expressed as cases per 100,000 population.

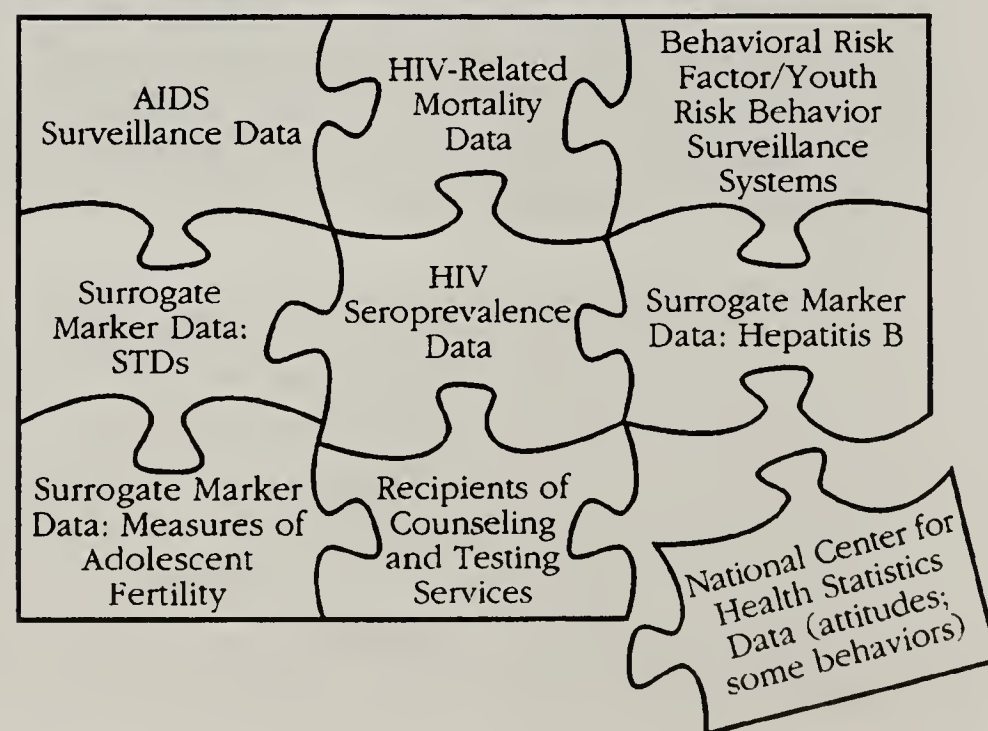
Surveillance is an ongoing process of information collection, analysis, interpretation, and dissemination to monitor the occurrence of specific health problems in populations. Surveillance is used to guide and evaluate public health policy and programs.

Research and Evaluation Guidelines from the Prevention Collaborative

Begin the process of ranking HIV prevention program priorities with epidemiologic data.

Epidemiologic data are key to ordering HIV prevention priorities. Using this science-based approach to planning is essential to sound public health practice and to gaining support for prevention programs. If these data are not available, state how they will be developed. Work collaboratively with state and local health departments and fellow service providers. Epidemiologic data are the starting point for programs, but not the final word. Combine epidemiologic data with information from other sciences: behavioral science and communications science. Develop a portrait of risk in your community. Know where risks (and their consequences) are now, where they have been, and where they're going. Ensure that epidemiologic data, communications, and behavioral science are used to direct scarce resources to those whose behavior places them at most risk *and* to those whose behavior you can affect. As

Readily Available HIV-Related Epidemiologic Data



one Prevention Collaborative partner put it, “Water needs to be dumped where the fire is now burning *and* on the dry grass around the fire to prevent it from spreading. A public health approach demands that interventions that benefit the greatest numbers be included alongside interventions targeting those at highest risk. This balance is critical regardless of funding.” For more information on formative research in program planning, see page 42. Also see Appendix B for information on epidemiology’s role in the HIV Prevention Community Planning process.

Collaborate at the community level to maximize limited resources and avoid duplicating efforts.

Research dollars and expertise are often scarce commodities. An important first step in designing research programs should be a literature review and analysis. Published research may answer key questions. Ideally, these “secondary data” as they are known, are supplemented with “primary data” from qualitative research you conduct, giving you insight into your particular community. Depending on your budget, inexpensive alternatives are focus groups and/or individual interviews. Community organizations with limited resources should combine efforts whenever possible, maximizing research funds, efficiency, and reach. A common private-sector collaborative effort is an omnibus survey, where various product manufacturers or marketers combine resources to commission research about their common target audiences.

Find out as much as you can about the target audience before you begin formal research.

Knowing as much as you can about the target audience — who they are, where they live, what they value, how they can be reached — is important to defining the scope of any formal

Project Action RFP

In Portland, Oregon, Population Services International (PSI) obtained reduced-cost services to support the teen-oriented safer sex promotion media campaign that is one component of the Project Action condom social marketing program. PSI issued a request for proposals, or RFP, to advertising firms in Portland, asking for assistance for the youth-oriented condom campaign. They selected one firm from among several responses. The firm produced three 30-second public service announcements for television and designed a campaign logo, posters, and letterhead. For \$435,000 of services and goods, PSI paid only \$100,000.

The relationship worked, according to project director Julie Convisser, because requirements and expectations from both sides were discussed thoroughly and frankly at the outset, and because the agency was dedicated to the issue and to making a difference in its community. For its part, Project Action made sure that the advertising agency received ample public recognition and credit for its efforts. Project Action also benefitted from the contributed services of a local market research firm that specializes in polling and surveys. The company conducted a survey of fast-food customers’ reactions to condom posters in restaurant bathrooms. The company charged \$3,000 for \$8,000 worth of services.

For more information, contact Helen Crowley at 202/785-0072



Formative Research

Formative research is conducted during the planning stages of program development. It forms the basis for behavioral goals, interventions, and later evaluation. Formative research can take many forms, including:

- analysis of epidemiologic data;
- literature reviews;
- analysis of demographic and psychographic data;
- focus group discussions, town meetings, or surveys to identify key issues, opportunities, and barriers;
- analysis of marketing data;
- pretesting concepts, messages, and channels of communication with consumers; and
- pilot testing with a small group before implementing a strategy community-wide.

Formative research is critical to successful social marketing programs. It doesn't have to be expensive. Much of the information you need is likely available through state or local health, education, or social services departments, at a local public or university library, or from other service providers. And you may get *pro bono* (free) or reduced cost help from a local market research firm, the research department of a large company, the advertising departments of local media (newspapers, radio, and TV), local advertising and public relations firms, and communications or public health departments at nearby universities and colleges. Many times these firms donate services or reduce costs because they believe in the cause or because they will get positive recognition. Some community groups put out RFPs (request for proposals) for *pro bono* work; others simply seek assistance directly from sources they have cultivated over time. The key, according to Prevention Collaborative partners, is: *Don't be afraid to ask!* The worst that can happen is that someone will say no. And the best is that you'll tap into a source of expertise for free. Also, remember that these nontraditional partners have technical expertise, but you bring HIV/AIDS expertise. It will be very important to act as the "client" and insist on technically correct messages.

research, such as behavioral studies. Examining your proposed consumers will probably pinpoint other groups you need more information about. For example, school-based studies don't include out-of-school or working youth. A prevention program for young people based solely on studies of in-school youth would likely not be effective with out-of-school youth.

Include interested parties in research design.

The target audience is certainly an interested party. But so are representatives of organizations that serve the target audience and policy- and decision-makers who can affect — for good or bad — project implementation. Ask yourself, “Who has a stake in this?” and then get them involved.

Make sure your research is culturally competent.

Involving members of the community in developing research questionnaires, crafting language, and in the interview process will help avoid miscommunication that can derail or invalidate research. Remember that culture can be defined by various criteria: sexual orientation and/or practices, race/ethnicity, gender, age, geography, religion, etc. Survey instruments are available that can be used “as-is” or modified to fit local needs. If you want to modify existing instruments, seek assistance from experienced researchers in how the modifications may affect the survey's credibility. Information about survey development, cultural competence, results of surveys, KABBs, and survey instruments is available through the CDC National AIDS Clearinghouse's Educational Materials Database.

CDC National AIDS Clearinghouse

■ *Calling 800/458-5231 connects you with reference staff and a wealth of HIV/AIDS information, from research and evaluation to prevention materials in more than 20 languages, to information on care, funding, and technical assistance. The CDC National AIDS Clearinghouse provides quick access to its varied databases through the reference staff or by using the NAC ONLINE Bulletin Board. A reference specialist can give you a free, customized database search on specific topics that interest you. Standard searches and specific bibliographies are immediately available on a variety of topics, such as abstinence programs, condom effectiveness and use, and so on. You can get many of the materials through the Clearinghouse, from publishers, or from the organization that developed them. For a minimal fee, NAC can arrange for permission to reproduce printed materials through its Document Delivery Service.*

Link research to needs and to interventions.

Research should be designed to answer a specific question that relates to a prevention need (known or suspected) and should be an integral part of all interventions subsequently developed and delivered. Formative research will help define the need (for example, how prevalent unprotected anal intercourse is within a given population at high risk), help define the factors that are creating the need (for example, young men aren't using condoms because the perceived social norm doesn't support condom use, condoms aren't available, condoms are perceived as decreasing sensation and pleasure, condoms mean you don't trust your partner), and allow you to create explicit process and outcome objectives (for example, peer-to-peer counseling will reach 100 members of the target population at least three times within a three-month period; of those receiving counseling, 75% will state a short-term intention to use condoms the next time they have intercourse). Ongoing evaluation will help assess how well the intervention is meeting its process and outcome objectives (how many people are actually reached, how many times, the behavioral results of those contacts, etc.).

Disseminate research results.

Sharing results with community members helps develop trust and establish consensus around an issue (such as a specific need or a specific intervention). Sharing results of what works and doesn't work also gives other groups ideas of what they can do. An informed community is better able to support HIV prevention efforts. Researchers and prevention program developers working collaboratively with a targeted audience have an obligation to share information — to work *with* the group, not *around* or *on* it. Nationally, the need for shared information grows as resources constrict, increasing the need for rapid and open dissemination of results. A competitive attitude about research results often defeats

collaborative work. Channels for sharing information vary in sophistication and availability, from scholarly journals and colloquia to public-access electronic bulletin boards. At the very least, all information should be made available to the National AIDS Clearinghouse, for on-line alert and distribution, and to the Prevention Collaborative, for distribution to participating organizations and their constituents.

Selected Readings on Research and Evaluation

AIDS Action Foundation. *A Survey of the HIV Prevention Community Planning Process, Report of Findings*. March 1995. Call 202/986-1300.

AIDSTECH. *A Guide for Evaluating AIDS Prevention Interventions: Tools for Project Evaluation*. Research Triangle Park, NC: Family Health International, 1992. (Available from AIDSTECH, 919/542-7040.)

Andreasen, A.R. *Cheap But Good Marketing Research*. Homewood, IL: Dow Jones-Irwin, 1988.

Crabtree, B.F. & Miller, W.F. *Doing Qualitative Research*. Newbury Park, CA: Sage Publications, Inc., 1992.

Damond, M., Gurvitch, A., Ludlow, N., et al. *Making Evaluation Part of Your HIV/AIDS Education Plan — Methods and Measures*. Washington, DC: American Red Cross, National Headquarters, Office of HIV/AIDS Education, 1993. (A photocopy of this material is available from the CDC National AIDS Clearinghouse Document Delivery Service, 800/458-5231.)

Debus, M. *Handbook for Excellence in Focus Group Research*. Washington, DC: Porter/Novelli. (Copies can be purchased for \$10.00 from the Academy for Educational Development, Eileen D'Andrea, 202/884-8882.)

Greenbaum, T.L. *The Handbook for Focus Group Research*. New York: Lexington Books, 1993.

Leviton, L.C., Hegedus, A.M. & Kubrin, A., eds. *Evaluating AIDS Prevention: Contributions of Multiple Disciplines*. San Francisco, CA: Jossey-Bass Inc., 1990. (A photocopy of this material is available from the CDC National AIDS Clearinghouse Document Delivery Service, 800/458-5231).

Leyva, M.A. & McKay, E.G. *Understanding Evaluation Techniques: The Building Blocks of Evaluation*. Washington, DC: National Council of La Raza, Center for Health Promotion, Hispanic Health Liaison Project, 1993. (Available from the National Council of La Raza, 202/785-1670.)

National AIDS Fund. *Evaluating HIV/AIDS Prevention Programs in Community-Based Organizations*. September 1993. (Copies may be ordered through the National AIDS Clearinghouse, 800/458-5231.)

National Council of La Raza, Center for Health Promotion. *Evaluating HIV/STD Education and Prevention Programs: An Introduction*. June 1992. (Copies may be obtained through the National Council of La Raza, 202/785-1670.)

Sarvela, P.D. & McDermott, R.J. *Health Education Evaluation and Measurement: A Practitioner's Perspective*. Dubuque, IA: William Brown Communications, Inc., 1994.

Smith, W.A., Helquist, M.J., Jimerson, A.B., Carovano, K. & Middlestadt, S.E. *A World Against AIDS: Communication for Behavior Change*. Washington, DC: Academy for Educational Development, 1993. (Copies may be purchased through the Academy for Educational Development, Eileen D'Andrea, 202/884-8882.)

U.S. Conference of Mayors. *Evaluation for HIV/AIDS Prevention Programs: Gathering Evidence to Demonstrate Results*. USCM AIDS/HIV Program, Technical Assistance Reports. December 1990. (Copies may be ordered through U.S. Con-

ference of Mayors, HIV/AIDS Division, 1620 I Street, NW, Washington, DC 20006. Fax: 202/887-0652. Free for Health Departments and CBOs, \$4.00 charge for for-profit organizations.)

U.S. Department of Education. *Understanding Evaluation: The Way to Better Prevention Programs*, 1993. Free copies are available from the National Clearinghouse for Alcohol and Drug Information (U.S. DOE publication no. ED/OESE92-41), 800/729-6686.

U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. *Handbook for Evaluating HIV Education*, 1992. (Copies available through CDC/NCCDPHP/DASH, 404/488-5330.)

U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. *Measurements in Prevention: A Manual for Selecting and Using Instruments to Evaluate Prevention Programs*. CSAP Technical Report Number 8, 1993. (Available through the National Clearinghouse on Alcohol and Drug Information, 800/729-6686.)

U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Prevention Marketing Initiative. *Coalitions and Public Health*. Draft, September 1994. (Copies may be ordered through the National AIDS Clearinghouse, 800/458-5231.)

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute, Office of Cancer Communications. *Making Health Communication Programs Work: A Planner's Guide*. NIH publication no. 92-1493, April 1992.

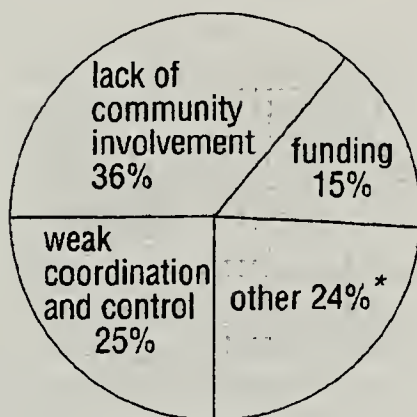
Coalition Building

How Do Coalitions Fit Into Prevention Marketing?

Broad community action is one of the three essential elements of a successful prevention marketing program and of HIV Prevention Community Planning. Building coalitions among varied organizations is one aspect of community participation. Coalition building usually happens before or during the program planning stage, but coalition membership and focus may change over time, as broad planning gives way to more targeted planning and then to intervention and evaluation. Potential coalition members will become apparent as your target audience is narrowed and defined. Any group in your community that has a stake in the well-being of your target audience — even if (*perhaps especially if*) their opinion differs from yours — should be considered as a potential member of the coalition. Diversity enriches the coalition, makes it multi-dimensional, and enhances its ability to serve the full spectrum of consumers.

Coalition building requires a commitment to shared decision-making, shared responsibility and accountability, and shared resources to respond to mutually agreed-upon community needs. It requires a formal commitment to work together, perhaps expressed as a common mission statement, a common vision, or even a legal contract. It doesn't require that everybody agree on everything all the time.

According to a Strategies newsletter reader poll, these are the major barriers coalitions face (other than lack of funding) to planning and implementing successful community-level prevention programs.



* other barriers (such as turf issues, lack of parental involvement, and community denial) 24%

Source: Strategies vol. 3 no.2 (Summer 1994) 6.

What Are the Benefits of a Community Coalition?

A coalition that functions well offers many benefits, according to the National Assembly of National Voluntary Health and Social Welfare Associations (a Prevention Collaborative member). A community coalition can:

- identify gaps in current services (a key part of needs assessment) and cooperate to fill those gaps;
- expand available services by cooperative programming and joint fundraising;
- provide better services through interagency communication about referral programs;
- develop a greater understanding of community needs by seeing the whole picture, not just a part of it;
- identify similar concerns and, at the same time, be strengthened by diverse perspectives that different members from varied backgrounds bring to the joint effort;
- reduce interagency conflicts and tensions by squarely addressing issues of competition and turf (especially important in a time of reduced resources);
- mobilize community action to effect needed changes through collective advocacy and the strength of individual organizations' constituents;
- achieve enhanced visibility and credibility with decision- and policy-makers, funders, the media, and the broader community;
- enhance staff skills by sharing information and holding joint training programs;
- conserve resources by avoiding duplication of services; and
- decrease costs through collective resource-saving opportunities.

Coalition Building Guidelines from the Prevention Collaborative

Form alliances with nontraditional partners to broaden the coalition's reach.

Private- and public-sector institutions in your community have a stake in HIV prevention — even those that don't yet know it! Cast your net as widely as possible to include nonhealth partners. For example, actively recruit area businesses who will directly benefit from HIV prevention by having a healthy workforce now and in the future, cutting health care costs, and contributing to the community's overall health and well-being.

Develop a shared vision and clear mission to succeed in coalition building.

As you begin forming a coalition, give special attention to developing common goals. It is essential to take the time to explicitly lay out the coalition's purpose, its vision, its mission, and how that mission will be achieved. As a group, review your joint vision, the common mission, and your collective progress regularly and make changes as needed to address changes in community needs, coalition membership, or other external or internal factors that can affect how the group functions.

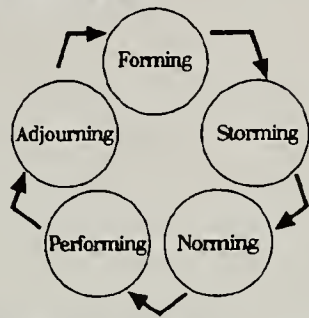
Define roles and responsibilities for each participating organization.

All roles and responsibilities — as well as accountability — must be defined and agreed upon at the beginning. Taking the time to detail these elements will reduce conflict later. Be aware, though, that roles and responsibilities can and will change over the life of the coalition. Staff changes (burnout, turnover, change in skills, etc.), changes in participating

Another Look at Coalition Building

Most of us are accustomed to looking at coalition building as linking with groups. But coalition building is also about linking and mobilizing individuals around an issue. For example, the Latinas: Partners for Health network has become a catalyst for uniting thousands of women around HIV/AIDS. Since 1990, more than 1,200 women nationwide have given their time and resources to HIV education and prevention. Careful planning set in motion a two-track strategy linking community and national leaders to share resources and strategies. The project also generated sorely needed resources: The Latina AIDS Action Plan and Resource Guide, Latinas: Partners for Health Partnership Directory, and Latinas: Partners for Health HIV/AIDS Partnership Plan. For more information about the network, contact HDI Projects in Washington, DC, at 202/452-3750.

Stages of Coalition Development



Forming. As a coalition comes together, feelings can range from excitement and enthusiasm to fear and resistance. The overriding tone is usually cordial.

Storming. After the formative stage, issues and agendas begin to surface. Slight to severe differences in the perception of facts, goals, methods, values, etc., are uncovered. Responses can range from withdrawing to overt fighting. The atmosphere is often chaotic.

Norming. Members stop talking at each other and start listening to each other. Needs, benefits, and limitations of collaboration are realized. Roles and responsibilities are determined; agreements are made concerning ground rules and group procedures. Constructive compromises are found. The tone is usually relieved and hopeful.

Performing. In this stage, the group produces. Members honor boundaries and agreements. Balance is maintained between content and process. Tone is characterized by appropriate participation, respect, and commitment.

Adjourning. In the final stage, the group disbands as its collaborative mission is accomplished or changes. Feelings can range from pride and a sense of accomplishment to relief or sadness that the group is separating. If a core group remains to address a new mission, new members will be recruited and the cycle will begin again.

organizations (for example, reduced or increased funding, new or changed program focus), and external changes (such as new school board members or other factors affecting the targeted audience or the broader community) can change participating organizations' functions within the collaboration. Take time to review roles and responsibilities periodically and modify as needed.

Educate each member organization's constituents about the coalition and its purpose.

Ensure that stakeholders in each member organization — board members, management, clients, funders, and so on — understand the nature and purpose of the coalition, and their organization's role in the coalition. This can help avoid conflicts that can arise when constituents don't perceive benefits to the coalition, perceive conflicts of interest among member organizations, or have had past negative experiences with other participating groups. Open or "under the table" divisiveness can thwart the coalition's success. Every member organization's constituents have a stake in the coalition's success, and every effort should be made to secure their buy-in and support.

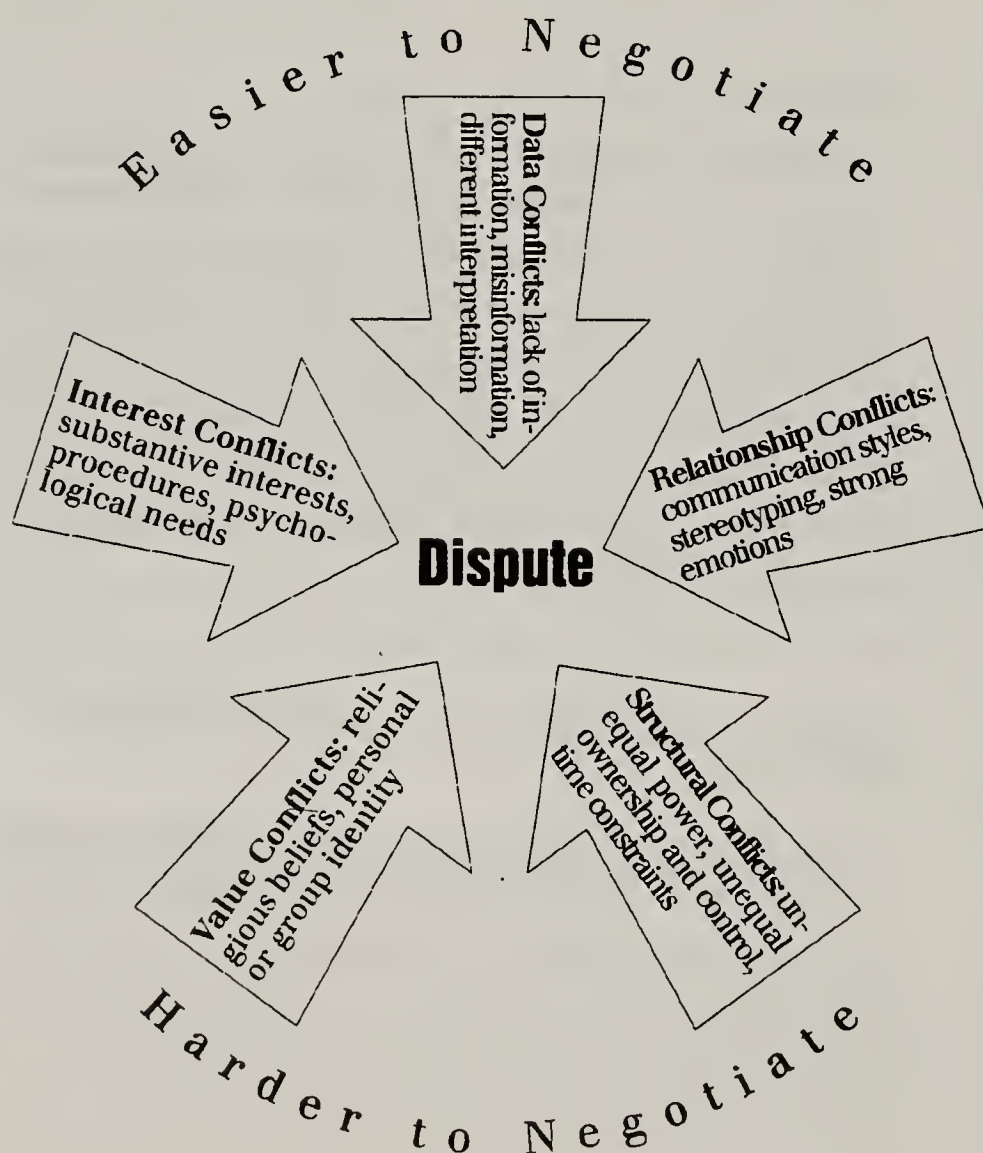
Obtain substantive input from the target audience.

Clearly, the target audience is a special constituency for the coalition and its members. If target audience members are not part of the staff of member organizations, consider including them in the coalition or as invited speakers or guests, as appropriate, at coalition business meetings. The approach will vary by community, but substantive consumer participation, through whatever channel, is vital to program success.

Clearly lay out plans for resolving conflicts, because disagreements are inevitable.

Lay out a process at the beginning to air grievances and resolve conflicts. Plan for compromise. Your goal is to avoid disintegration at the hour of greatest need, when members must pull together and not apart. If necessary, seek mediation from an outside source; try to agree upon this source as you form the coalition — don't wait until you're in the middle of a conflict to come up with an objective facilitator.

Sources of Group Disputes



Academy for Educational Development. *Handbook for HIV Prevention Community Planning*. Page 3-6, April 1994.

Arrange for consistent representation from each coalition member.

Active participation in the coalition may require a dedicated staff member or at least that a staff member's job responsibilities specifically include these duties. Member organizations should assess their ability to participate and adjust staff workloads as needed. Discuss representation at the beginning — as a group, determine the participation ground rules: what is acceptable in terms of missed meetings, sending substitutes, and so on.

Share information among member organizations to strengthen coalitions.

Information is power. Successful coalitions function on trust and shared power. Lack of trust, resulting in information isolation and power imbalances, can be deadly to a coalition. Lines of communication should be fluid and reflect the unique nature of your coalition — some member organizations will naturally be in closer contact than others, but make attempts to be inclusive. Sometimes, informal communication among the leadership will be enough. Other situations may require more formal channels. Whatever the process, it should be frank and open. Remember, though, that communication about specific clients will require their informed consent. Lay out the ground rules for communication about clients at the beginning.

Make sure the coalition is prepared to speak as one voice.

It is vital that coalition members deliver the same message and reiterate core messages over and over. The unified voice of various organizations can reorder community thinking. Conversely, if your members are delivering essentially the

same message, but slightly differently, this can create the impression that unity is lacking. And remember the importance of repetition — over time, many drops of water created the Grand Canyon!

Selected Readings on Coalition Building

General Readings

Amherst H. Wilder Foundation. *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey*. (Call 612/642-4000.)

Community Anti-Drug Coalitions of America. *Community Coalitions: Developing a Public Relations Plan*. CADCA Strategizer No. 4. Alexandria, VA: CADCA, 1994. (A photocopy of this material is available from the CDC National AIDS Clearinghouse Document Delivery Service, 800/458-5231.)

Feighery, M.S. & Rogers, T. *Building and Maintaining Effective Coalitions*. Palo Alto, CA: Stanford Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, Stanford University School of Medicine, 1990.

Kreitzmann, J.P. & McKnight, J.L. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago, IL: Center for Urban Affairs and Policy Research, Northwestern University, 1993. A collection of case studies of successful interventions in troubled communities nationwide. The theory of this book is that individuals, associations, and institutions have unique assets that can be used to better communities.

The National Assembly of National Voluntary Health and Social Welfare Organizations. *The Community Collaboration Manual*. Washington, DC: The National Assembly, 1993. (Copies available for \$10.95 + \$3.00 shipping and handling from the National Assembly, 202/347-2080.)

The National Council of La Raza. *Do's and Don'ts For An Inclusive HIV Prevention Community Planning Process: A Self-Help Guide*. Washington, DC: NCLR, 1994. (For more information, call 202/785-1670.)

Strategies, a quarterly newsletter published by Join Together, a national resource center for communities fighting substance abuse, Boston University School of Public Health; 421 Stuart St., 6th Floor, Boston, MA 02116; 617/437-1500. Although this newsletter specifically focuses on substance abuse programming, articles can apply to HIV prevention. Articles include topics such as putting public policy issues on coalition agendas, tools for social change, lessons from MADD (Mothers Against Drunk Driving) on changing public policy, case studies, and resources.

Special Topic: Conflict Resolution

Fisher, R. & Ury, W. *Getting to Yes: Negotiating Agreement Without Giving In*. New York: Penguin Books, 1983.

Fisher, R. & Brown, S. *Getting Together: Building Relationships As We Negotiate*. New York: Penguin Books, 1989.

Susskind, L. & Cruikshank, J. *Breaking the Impasse: Consensual Approaches to Resolving Public Disputes*. New York: Basic Books, Inc., 1987.

Weeks, D. *The Eight Essential Steps to Conflict Resolution*. New York: G.P. Putnam & Sons, 1992.

Health Communications

Health communications is the portion of prevention marketing programs that deals with messages, their delivery, and their evaluation. Because health communications is often the most visible part of prevention marketing, the terms are often used synonymously. But health communications messages and channels of delivery — street outreach, health fairs, peer counseling, safer sex workshops, public service announcements, and so forth — are not the only component, or even the most important component, of an integrated prevention marketing program. Each of these components is the result of research with intended consumers and reflects a thorough understanding and appreciation of the target audience's needs, beliefs, behaviors, lifestyle, demographics, psychographics, and other characteristics.

Health Communications Guidelines from the Prevention Collaborative

Include the target audience in message and materials development, pretesting, pilot testing, delivery, and evaluation.

Consider — and include — consumers in all stages of health communication program design, especially in formative research that influences message content and delivery channels. For example, youth can become involved through a variety of sources, including collaborating educational, civic, social, and governmental organizations and institutions. It is critical to ensure that target audience members are adequately prepared to participate meaningfully. Traditionally disenfranchised and/or marginalized target audiences —

including people who are young, economically disadvantaged, of color, gay, lesbian, bisexual, transgendered, drug-using, homeless, jobless, etc. — may not have the background and experiences that coalition members have, may not be prepared to operate in a group that runs on Robert's Rules of Order, or may not see the benefits to structuring discussions in the way the coalition does. Coalition members must consider the desired outcome/s of including the target audience and then structure opportunities for involvement that allow participating consumers to feel successful, useful and not used, and valued. These opportunities should also capitalize on target audience members' existing skills, talents, and aptitudes, while offering them challenges to grow. This is not easy. Coalition members may require education and training in working "outside the box" and in perceiving consumers as colleagues rather than as a group of people simply to be targeted for interventions.

Create and deliver messages that are clear, direct, and appropriate to the target audience.

To be effective, messages must speak to the target audience in language and a context they will understand and appreciate. The dialogue of a target audience — particularly young people — can change quickly, so messages must be adaptable, without jeopardizing their credibility. Message pretesting and pilot testing will shed light on the target audience's reaction before a program is delivered. As the program is underway, ongoing evaluation will pinpoint language, content, channels of communication, or other aspects that need to be adapted based on the current situation.

Look to consumer research to guide message content and style. A general rule of thumb: *Fear-based messages will probably not be effective.* Based on target audience research, consider embedding HIV prevention messages in a comprehensive approach to health and well-being. Research may indicate

that the target audience will respond well to prevention messages incorporated into positive concepts that may include self-esteem, self-respect, healthy mind/healthy body, sexuality and sex, as well as other health-related topics such as nutrition or exercise. Research will guide whether messages should be direct and didactic (e.g., “Use latex condoms.”) or less direct (perhaps a skill that is modeled by a peer, such as talking with a partner about condoms). Research will reveal the target audience’s practices, beliefs, attitudes, skills, and knowledge. For example, it may indicate that abstinence, often shunned by prevention program designers as unrealistic for young people, is a desired option and is a prevention message that should be included in your communications.

Use research to guide decisions about messengers.

It is important to remember that the messenger is as important as the message. Formative research with the target audience will spotlight individuals and/or groups they find credible and whose word they will act on. This investigation is crucial, because it may reveal target audience values that can surprise planners. For example, national research with young adults (18 to 25) on HIV prevention messages has shown that effective messengers need not mirror the target audience in terms of race/ethnicity, gender, sexual orientation, or other traits program planners would often suspect. Instead, the research showed that the single most important characteristic for messenger credibility is age — young adult target audience members want to see and hear people their own age talking about HIV prevention. In your community, it is possible that age may be an important characteristic, but not the *most* important. Your research may show that another characteristic — sexual orientation, gender, race/ethnicity, etc. — may be more important to your chosen target audience. Let research with your target audience guide your

choices of credible messengers, messages, channels of delivery, etc.

Programs should demonstrate their cultural competence by clearly incorporating the target audience's values into campaign materials and activities. Target audience members can provide insights into messages that are sensitive to culture, race/ethnicity, gender, sexual identity, age, and other characteristics.

Work with the target audience to ensure linguistic accuracy.

Develop messages and materials for non-English speakers and readers. Translations of English to other languages usually do not convey the desired messages and are often insensitive, if not offensive. Other groups that have their own language — for example, young people, drug users, sex workers, etc. — should also be involved in message development.

Consider the various needs and behaviors of the entire range of target audiences when developing HIV prevention interventions.

Audience segmentation is a key principle of prevention marketing. Broad segmentation — for example, along the lines of age, gender, race/ethnicity, or sexual orientation — will not capture the differing needs and perspectives of subgroups within these categories or the cross-cutting perspectives that may be found in varied demographic groups. Many consumers belong to more than one potential target audience. For example, a well-known athletic gear marketer segments according to innovators (the first to try a new product) and across demographic lines — young and old, of varied races and ethnicities, of both genders. The salient characteristic is whether the target audience member is game for new things and can diffuse the innovation to others

in his or her segment. In HIV prevention programs, bartenders in gay and lesbian bars have been targeted because patrons perceive them as opinion leaders/style setters. The bartenders' race/ethnicity, gender, age, socioeconomic status, etc., are not the most important characteristics in their ability to promote safer behaviors successfully.

Armed with formative research into varied target audiences and weighing program resources and priorities, focused communications should be developed as specifically as possible for each consumer group. Only after research is done can messages be focused. For example, research will show whether a single message will suffice for all female adolescents, or whether messages should be different for those who are sexually active now, were sexually active in the past but are not now, or will be sexually active; for those who are straight, bisexual, lesbian, or questioning; for those who use condoms consistently for vaginal intercourse (and/or oral and/or anal intercourse), those who occasionally use condoms for vaginal intercourse, or those who have never used condoms for vaginal intercourse; and so on.

Work to develop community support for prevention.

Communities may be reluctant to provide programming for those most at risk because they and their behavior are controversial — this may be especially true for young people who are gay, bisexual, lesbian, or transgendered, or who engage in other behaviors such as drug use outside the mainstream of the broader population. The prevailing climate in a community will affect the community's acceptance of specific messages. But you should make every attempt to ensure the climate does not deter the development of health messages for any group. It is vital to have community support for prevention messages and materials that may be viewed as controversial. Careful and thorough community involvement

through linkages, coalition building, seeking out stakeholders and gatekeepers, and other preparatory work may ease the way. Having a solid science base for your program — in epidemiology, behavioral science, and communications science, as demonstrated by formative research results — will help ensure that public discussions (and debates) don't simply boil down to what one side feels or believes versus what the other side feels or believes. For more information on formative research, see page 42; for more information on linkage and coalition building, see pages 55–62.

Pursue partnerships with a broad range of community organizations.

Partnerships, coalitions, and cooperatives extend the reach of prevention messages. Nontraditional partners, such as local marketing firms, public relations and advertising agencies, and even local media all bring valuable skills and expertise to the collective table.

Large and small Media

Traditional “mass” media channels such as network television and national consumer magazines continue the recent trend of splintering into smaller and smaller niche markets. The big three networks are now fighting for survival with other growing free and for-fee networks, giving viewers hundreds of channels to choose among. Broadly defined publications such as *Life*, *Time*, *Reader's Digest*, and *TV Guide* once dominated the magazine industry. But a proliferation of narrowly targeted titles such as *Cooking Light*, *Organic Gardener*, *Soap Opera Digest*, and *Country Woman* now share the shelf. Both TV and print media are being muscled by online communications offered to consumers through subscriber services such as America OnLine and Prodigy. National programs like the Prevention Marketing Initiative make use of general mass media as well as targeted mass media — for example, PMI public service announcements run on network and affiliate TV channels; the show “SMART SEX” ran on MTV.

At the community level, focusing on “small” media channels has become an important strategy for designing and delivering public health interventions. These so-called “personal” media will likely be more effective on a local level than focusing on national, broad demographic audience publications and shows. Small media can range from the obvious (local newspapers, community newsletters, local radio) to the less conventional (posters, seminars and workshops, special events, contests, booklets, brochures, door hangtags, “baseball” cards).

Conduct research with your target audience to determine the best channels through which to reach them.

Carefully select media and other channels of distribution to most effectively reach consumers.

What has your target audience told you about credible messages and messengers? About where, when, and how messages should be delivered? Any chosen health communications component should be thoroughly supported with research with the target audience, not just the “gut feelings” of coalition members or program staff. *“I think...”* isn’t sufficient to justify using scarce and precious resources.

In proposing possible channels of communication to the target audience, think creatively. Prevention marketing emphasizes using the most effective channel for reaching the target audience, and that may not be PSAs. Television, radio, and other mass media may not always be the best ways to reach certain groups. Interactive video, peer educators, street outreach, electronic bulletin boards or “talk” forums, hotlines, improvisational theater, and other possibilities should be considered. In particular, evaluate niche media, like alternative newspapers and the so-called “zines,” very specialized publications that have small but extremely dedicated markets.

Evaluate both the process and behavioral outcomes of your health communications efforts.

All prevention program elements should include both process and outcome evaluation. Measurable results of successes, near-misses, and failures should guide future activities.

Media Relations at the Local Level

As print and electronic media cut budgets and downsize, it's up to community groups to provide reporter-ready information in the form of facts, stories, and articles. Even the television media will be more interested in something you prepare that's ready for broadcast. This air-quality tape is called “B-roll” (for background) and generally shows generic visuals relevant to a story. For example, for a story on preventing perinatal HIV transmission, you might show pregnant women with health care providers, mothers and babies, and infants in hospital isolettes. You might also include brief comments from your organization's staff or clients.

Planning and research are the keys to success in placing your story. Find out what the media want, what format they prefer, and the angles they might cover. Make it as easy as possible for reporters to use your information. Materials should get to the point quickly — consider fact sheets, information kits with relevant articles and photos or other graphics, and posters. Personal follow up is extremely important. Don't send your ideas into a void — call ahead to let reporters know what's coming and why they need it and follow up to encourage coverage. Use the information you get from these interactions to fine-tune your future efforts. —

Many tools are available to help local groups organize their media relations effort. PMI recently published two technical assistance documents: Media Relations and Issues Management, available through the National AIDS Clearinghouse, 800-458-5231. And PMI partner HDI Projects in Washington, DC, has published HIV/AIDS Media Action Guide: A Planning and Promotions Guide for Community Leaders; call 202/452-8750.

Selected Readings on Health Communications

Backer, T.E., Rogers, E.M., & Sopory, P. *Designing Health Communication Campaigns: What Works?* Newbury Park, CA: Sage Publications, Inc., 1991.

Backer, T.E. & Rogers, E.M., eds. *Organizational Aspects of Health Communications Campaigns: What Works?* Newbury Park, CA: Sage Publications, Inc., 1993.

Bracht, N., ed. *Health Promotion at the Community Level.* Newbury Park, CA: Sage Publications, Inc., 1990.

Edgar, T., Fitzpatrick, M.A., & Freimuth, V.S., eds. *AIDS: A Communication Perspective.* Hillsdale, NJ: Lawrence Erlbaum Associates, 1992.

Freudenberg, N. & Zimmerman, M.A., eds. *AIDS Prevention in the Community: Lessons from the First Decade.* American Public Health Association, 1995. To order, call 202/789-5667.

Gross, G.M. *Active Communities, Healthy Families.* Madison, WI: Center for Public Representation, 1987.

Kotler, P. & Roberto, E.L. *Social Marketing: Strategies for Changing Public Behavior.* New York: The Free Press, 1989.

The Marin Institute for the Prevention of Alcohol and Other Drug Problems. *Advocating for Policy Change*, a 16-page workbook available free. Write to: 24 Belvedere St., San Rafael, CA 94901.

Morris, L.L. & Fitz-Gibbon, C.T. *How to Measure Program Implementation.* Newbury Park, CA: Sage Publications, Inc. 1978.

National Library Service for the Blind and Physically Handicapped. *Reaching People.* Washington, DC: Library of Congress, 1980.

Peter Glenn Publications. *National Radio Publicity Directory.* New York: Peter Glenn Publications, 1982.

Rice, R.E. & Atkin, C.K., eds. *Public Communication Campaigns*, 2nd ed. Newbury Park, CA: Sage Publications, Inc., 1991.

Sage Publications, Inc. *Media Advocacy and Public Health*. Explains the concepts of media advocacy through eight case studies and gives practical advice on using media advocacy to effect policy change. Available in hardback (\$36) and softcover (\$16.95) from Sage Publications, Inc., 2455 Teller Rd., Newbury Park, CA 91320-2218; 805/499-9742 (phone) and 05/499-0871 (fax). There's a \$2 handling charge per order.

Salmon, C.T., ed. *Information Campaigns: Balancing Social Values and Social Change*. Sage Annual Review of Communication Research, Volume 18. Newbury Park, CA: Sage Publications, Inc., 1989.

Television Digest. *Television Factbook*. Washington, DC: Television Digest, 1982.

TV Publicity Outlets. *TV Publicity Outlets — Nationwide*. Washington Depot, CT: TV Publicity Outlets, 1982.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Health Information Center. *Working with the Print Media* (for the Healthy Older People Program), DHHS publication no. Y0182. Washington, DC: U.S. Dept. of Health and Human Services, 1982.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health. *Making Health Communication Programs Work: A Planner's Guide*, NIH Publication No. 92-1493. Washington, DC: U.S. Dept. of Health and Human Services, 1992.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung, and Blood Institute. *Churches as an Avenue to High Blood Pressure Control*, NIH publication no. 87-2725. Washington, DC: U.S. Dept. of Health and Human Services, 1987.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung, and Blood Institute. *Community Guide to High Blood Pressure Control*, NIH publication no. 82-2335. Washington, DC: U.S. Dept. of Health and Human Services, 1982.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung, and Blood Institute. *With Every Beat of Your Heart: An Ideabook for Community Heart Health Programs*, NIH publication no. 87-2641. Washington, DC: U.S. Dept. of Health and Human Services, 1987.

Health Communications Resources

Emerson-Tufts Program in Health Communication offers information on effective health communications programming, including written materials (*Health Communication Journal* and *AIDS: Effective Health Communication for the 90s*, edited by Director Scott E. Ratzan, M.D.) and a Worldwide Web page. Contact 617/578-8745 (phone) or 617/578-8749 (fax).

National Organization of Black County Officials, NOBCO, a Prevention Collaborative member, provides capacity building and programmatic technical assistance to increase the level of knowledge and skills in HIV/STD prevention among staff of CBOs, health and human services agencies, and national programs targeting ethnic minority youth. Maria D. Lopes, Executive Director, and Patricia Carter, Project Coordinator; 420 First St., SW, Suite 500, Washington, DC 20001; 202/347-6953 (phone), 202/393-6596 (fax).

AIDS Foundation of Chicago maintains a prevention/education committee of HIV health educators from throughout the Chicago metropolitan area. Contact David Ernesto

Munar, 312/922-2322 (phone); 312/922-2916 (fax); 11 S. Wells, Suite 300, Chicago, IL 60607.

Cultural Competence Resources

A Prevention Collaborative partner, the Filipino Task Force on AIDS, Daniel E. Toleran, Executive Director, offers ethnic-specific HIV/AIDS education and care programs and services. They also have a locally produced documentary called "Celebrating Our Lives" about Filipinos living with and affected by HIV/AIDS, and written materials on product development and market testing for small print media (posters, condom kits, and brochures). Call 415/703-9880; fax 415/864-7482.

Cultural Awareness and Sensitivity: Resources for Health Educators. From the Association for the Advancement of Health Education (a Prevention Collaborative member), Reston, VA. Call 703/476-3437; fax: 703/476-6638

La Guia, A Resource Guide for Gay, Lesbian and Transgendered Latinas/os. Published by the National Latino/a Lesbian and Gay Organization (LLEGO), a Prevention Collaborative partner, and the CDC National AIDS Clearinghouse, May 1995. Call 800/458-5231.

U.S. Conference of Mayors. *Assessing the HIV Prevention Needs of Gay and Bisexual Men of Color.* June 1994. Call 202/293-7330. Also *HIV Prevention Community Planning Profiles: Assessing Year One.* Fax request to 202/887-0652. USCM is a Prevention Collaborative partner.

Wandering Star Productions. *Training for Cultural Competence in the HIV Epidemic* (video with booklet). University of Hawaii-Manoa, Kapiolani Medical Center, AIDS Education and Training Center, 1992. To order, call 808/737-0934.

Appendix E

Glossary of Terms

Audience segmentation — subdividing an overall population into homogeneous subsets of target audiences in order to better describe and understand a segment, predict behavior, and formulate tailored messages and programs to meet specific needs.

Behavioral science — an area of social sciences research that examines individuals' behaviors in depth; it explores what people do and why they do it.

Channels of communication — the ways in which individuals receive information; includes large and small media, one-on-one communication, and live entertainment.

Communications science — systematic, informed creation, dissemination, and evaluation of messages to affect knowledge, skills, attitudes, beliefs, behaviors, and, ultimately, health outcomes.

Cultural competence — cultural sensitivity combined with the ability to successfully intervene in a specific population.

Demographics — statistics relating to human populations, including size and density, race, ethnicity, growth, distribution, migration, births, deaths, and their effects on social and economic conditions.

Determinants of behavior — the external and internal factors that may determine or influence individuals' actions.

Epidemiology — the study of the patterns and determinants of health and disease in populations.

Evaluation — a systematic process that records and analyzes what was done in a program or intervention, to whom, and how (process), and what short- and long-term behavioral effects (outcome) were experienced as a result.

External determinants of behavior — those forces outside the individual that affect his or her behavior (e.g., availability of condoms; laws governing sexual activity).

Force field analysis — an analysis of the forces in a community that may inhibit, impede, or assist a program or course of action.

Formative research — systematic investigations during the development phase of a program or intervention that deepens the planners' understanding of the audience and the environment and that assists in subsequent planning and evaluation.

Gatekeepers — influential individuals who serve as access points to the target audience, e.g., school teachers, doctors, or public service directors at local television stations.

Incidence — the number of new cases of a disease or condition that occur within a given time, often one year.

Internal determinants of behavior — the forces inside the individual that affect his or her perception of a behavior (e.g., the belief that condoms are not “cool”).

Key informants — individuals who are knowledgeable about and influential with particular segments of the population.

Large media/mass media — media channels that reach large or nationwide audiences, such as the three network television networks or national magazines.

Lifepoints — key places individuals visit in their daily lives, e.g., school, stores, restaurants.

Marketing mix — the balance of components in a marketing strategy that reflects the different needs of a given audience; the “4 Ps”: product, price, promotion, and place.

Needs assessment — the process of obtaining and analyzing information from a variety of sources in order to determine the needs of a particular population or community; similar to “marketplace assessment.”

Niche media — media targeted to small, specialized audiences.

Outcome evaluation — a type of evaluation that determines whether a particular intervention had a desired impact on the targeted population's behavior; whether the intervention provided made a difference in knowledge, skills, attitudes, beliefs, behaviors, and health outcomes.

Prevalence — the number of individuals living with a disease or condition during a given time.

Prevention marketing — CDC's “brand” of social marketing, which incorporates behavioral science and community participation into the principles and processes of social marketing.

Primary data — qualitative or quantitative data that are newly collected in the course of research.

Process evaluation — a descriptive assessment of the implementation of program activities; what was done, to whom, and how, when, and where.

Psychographics — statistics relating to the spheres of influence on a target audience and their behavior; includes information about target audience's work and leisure activities, associations with peers, willingness to try new things, social norms, and hopes, fears, and dreams.

Secondary data — published, already available data.

Self-efficacy — an individual's belief that he or she can do a desired behavior.

Seroprevalence — the percentage of individuals infected with HIV in a given population at a specific point in time.

Situation analysis — review and analysis of the community's current environment with regard to HIV and HIV prevention, including support for and potential barriers to prevention efforts; this information is used in making decisions about target audiences, behavioral objectives, geographic area to cover, and players to involve.

Small media — often called "personal media"; media targeted to relatively small, specialized audiences and interests, e.g., seminars and workshops, door hangtags.

Social marketing — the use of modern marketing principles and methodologies to increase the use of a socially beneficial idea, product, or practice; key features include a thorough understanding of the target audience, creation of beneficial exchange relationships to influence audience behaviors, and a management approach characterized by continuous monitoring and alteration of interventions as needed.

Social norms — perceived standards of behavior or attitude accepted as usual practice by groups of people.

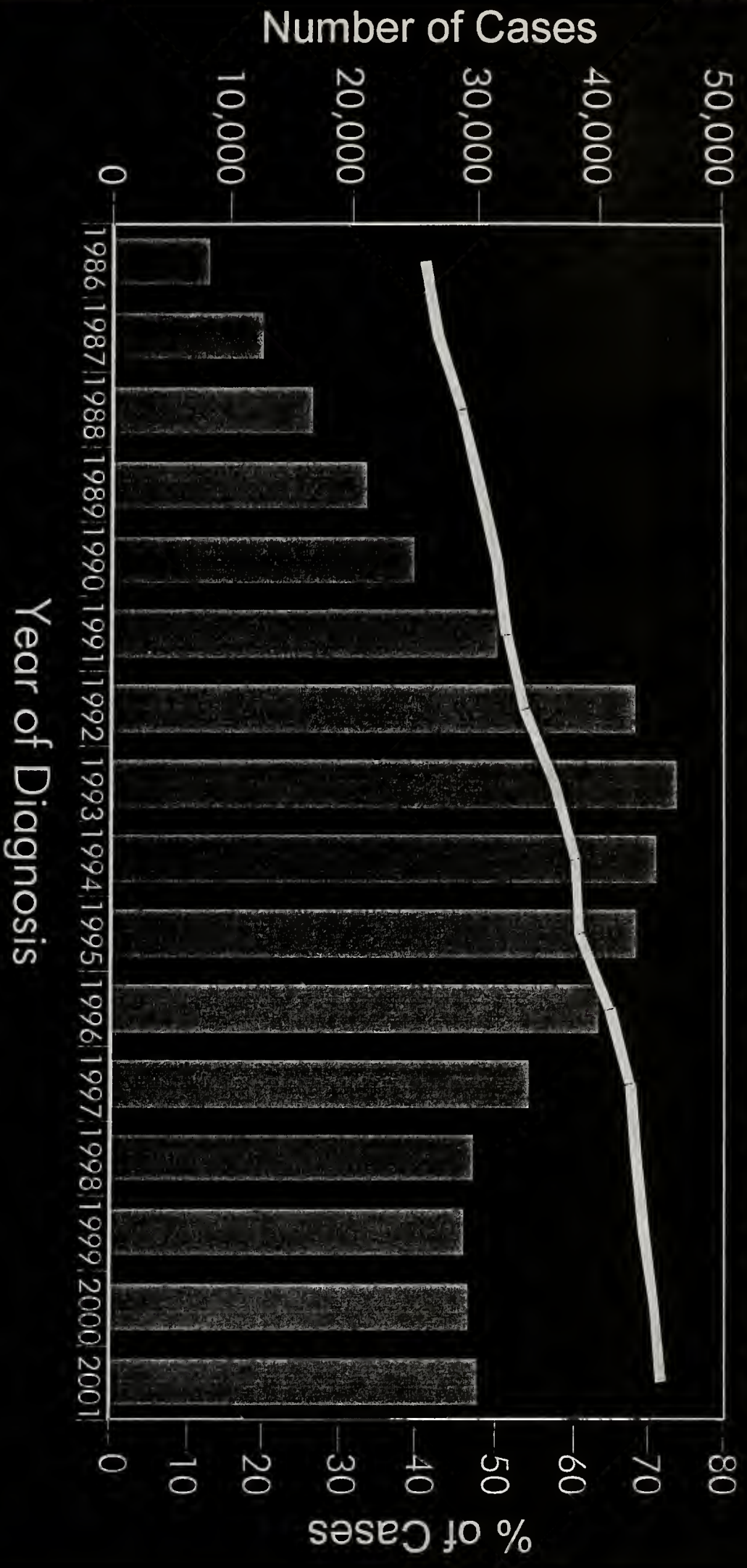
Stakeholders — those who have an interest in and can affect implementation of an intervention or program; key players; influentials.

Surrogate indicators — data such as STD or hepatitis B rates, which do not directly measure HIV infection, but that may indicate unsafe sexual behavior that can put people at risk of HIV infection.

Surveillance — an ongoing process of information collection, analysis, interpretation, and dissemination to monitor the occurrence of specific health programs in populations.

'zines — specialized publications that have small but extremely dedicated markets.

Estimated* AIDS Incidence in Racial/Ethnic Minorities** January 1986 - December 2001, United States



*Adjusted for reporting delays

**Includes Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native persons with AIDS



Estimated AIDS Incidence in Racial/Ethnic Minorities, January 1986 – December 2001, United States

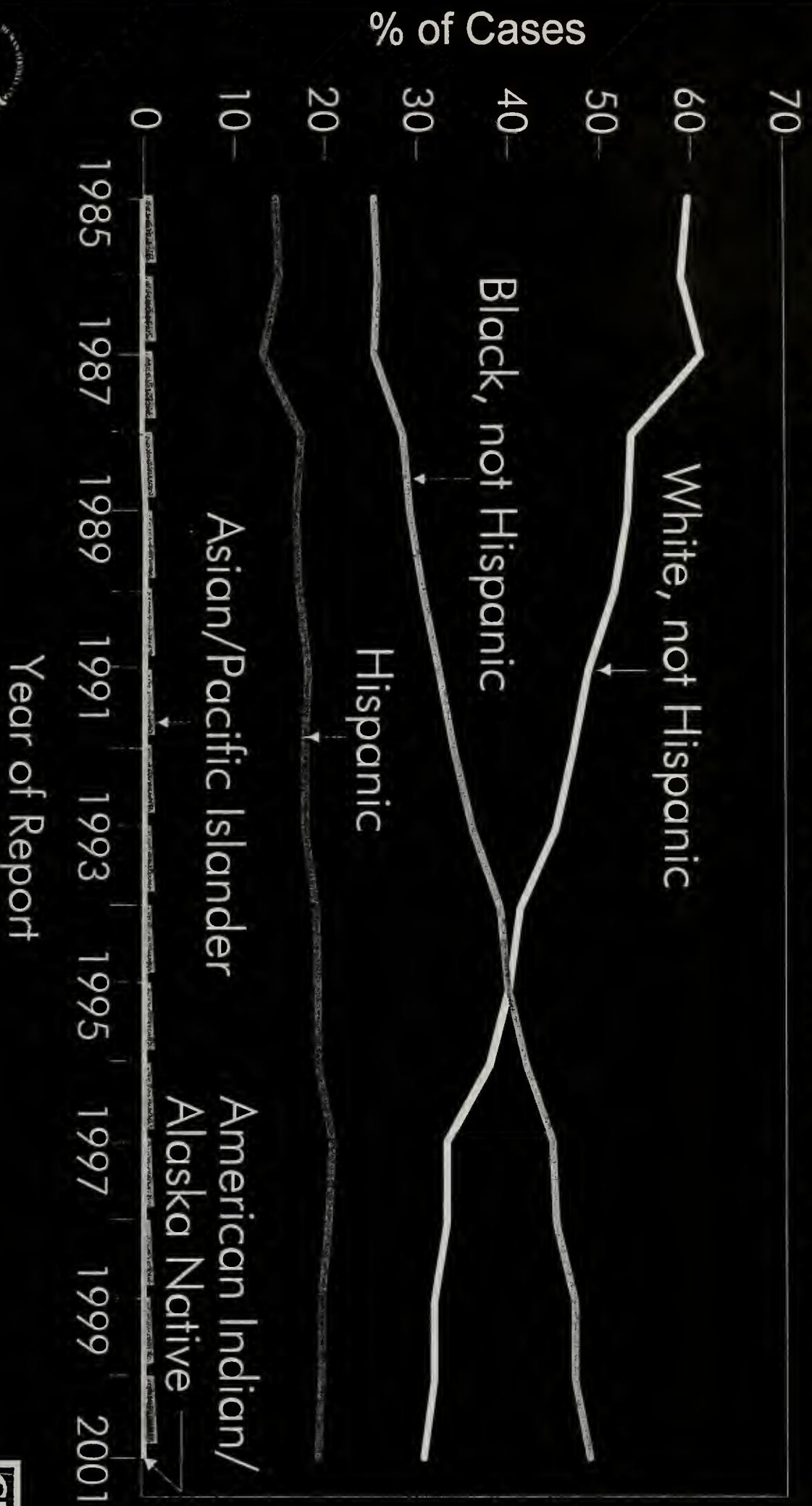
The number of AIDS cases diagnosed increased each year from 1986 through 1994. The 1993 expansion of the AIDS case definition resulted in an increase in the number of AIDS cases reported. In 1996, the introduction and widespread use of antiretroviral therapies, which slows the progression of HIV infection to AIDS, resulted in declines in AIDS incidence.

The same pattern occurred among all racial/ethnic groups. Among minorities, the number of AIDS cases began to decrease in 1994 as the effect of the change in the case definition began to wane; nevertheless, the proportion of AIDS cases in minorities has continued to increase each year.

In 2001, an estimated 29,723 AIDS cases were diagnosed among minority racial/ethnic groups, which accounted for more than 70% of all AIDS cases diagnosed in 2001 in the United States.



Proportion of AIDS Cases, by Race/Ethnicity and Year of Report, 1985 – 2001, United States



Proportion of AIDS Cases, by Race/Ethnicity and Year of Report, 1985 - 2001, United States

The proportional distribution of AIDS cases among racial/ethnic groups has shifted since the beginning of the epidemic. The proportion of cases has decreased among whites and increased among blacks and Hispanics. As of 1996, a greater proportion of cases was reported among blacks than among whites.

The proportion of cases reported among Asian/Pacific Islanders and American Indian/Alaska Natives has remained relatively constant, representing approximately 1% of all cases.

In 2001, 49% of persons with AIDS were black, 31% were white, 19% Hispanic, 1% Asian/Pacific Islander, and less than 1% American Indian/Alaska Native.



AIDS in Blacks and Hispanics

Of the 816,149 AIDS cases reported to CDC through 2001, blacks and Hispanics accounted for

57%	of total
78%	of women
79%	of heterosexuals*
82%	of children

Of AIDS cases reported in 2001, 68% were among black and Hispanic adults and adolescents.

*Heterosexual injection drug users and persons with heterosexually acquired HIV



AIDS in Blacks and Hispanics

Blacks and Hispanics account for a disproportionate share of AIDS cases. More than half of the AIDS cases reported in the United States were in blacks and Hispanics.

More than three-fourths of the women and children reported with AIDS were black or Hispanic.

In 2001, 68% of AIDS cases reported among adults and adolescents were in blacks and Hispanics.



Estimated* AIDS Cases in Adults and Adolescents by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States

Exposure category	White		Black		Hispanic	
	not Hispanic		not Hispanic		Hispanic	
	Number	%	Number	%	Number	%
Men who have sex with men (MSM)	243,806	70	97,325	30	57,007	37
Injection drug use (IDU)	45,837	13	124,688	39	58,607	38
MSM and IDU	27,281	8	18,794	6	8,883	6
Heterosexual contact	22,823	7	72,432	23	26,159	17
Other/not identified**	10,323	3	7,432	2	2,439	2
Total	350,070		320,671		153,095	

*Data adjusted for reporting delays and redistribution of cases initially reported without risk information, as of December 2002

**Includes patients with hemophilia or transfusion-related exposures and those whose medical record review is pending; patients who died, were lost to follow-up, or declined interview; and those with other or undetermined modes of exposure



Estimated AIDS Cases in Adults and Adolescents, by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States

Most AIDS cases in adults among whites, Asian/Pacific Islanders, and American Indian/Alaska Natives have been in men who have sex with men (MSM). Among blacks, injection drug use was the most frequent mode of exposure to HIV (39%). Among Hispanics, similar proportions were exposed through MSM and injection drug use.



Estimated* AIDS Cases in Adults and Adolescents by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native	
	Number	%	Number	%
Men who have sex with men (MSM)	4,178	66	1,236	47
Injection drug use (IDU)	682	11	606	23
MSM and IDU	242	4	371	14
Heterosexual contact	908	14	327	12
Other/not identified**	365	6	77	3
Total	6,374		2,616	

*Data adjusted for reporting delays and redistribution of cases initially reported without risk information, as of June 2002

**Includes patients with hemophilia or transfusion-related exposures and those whose medical record review is pending; patients who died, were lost to follow-up, or declined interview; and those with other or undetermined modes of exposure



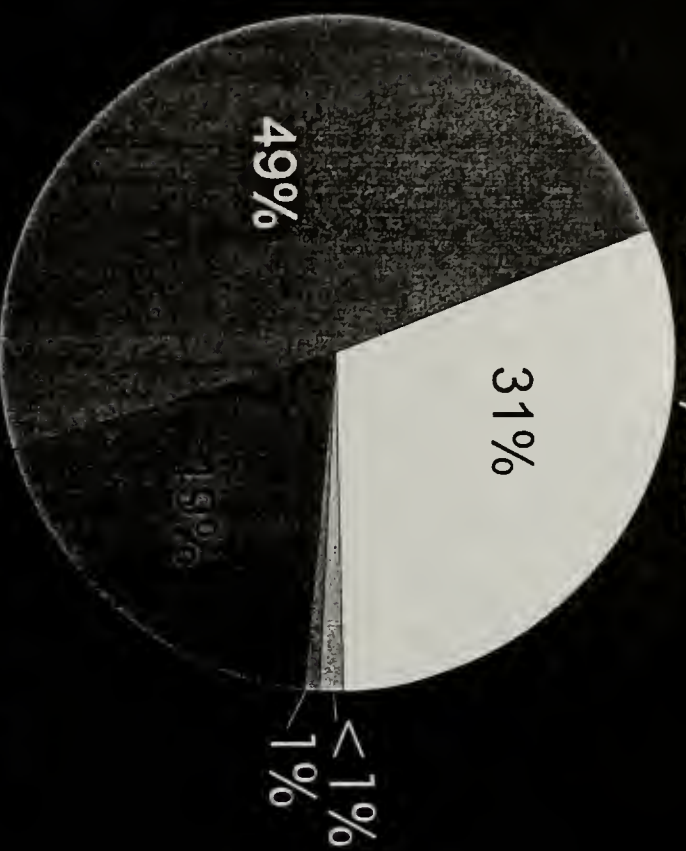
Estimated AIDS Cases in Adults and Adolescents, by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States

Most AIDS cases in adults among whites, Asian/Pacific Islanders, and American Indian/Alaska Natives have been in men who have sex with men (MSM). Among blacks, injection drug use was the most frequent mode of exposure to HIV (39%). Among Hispanics, similar proportions were exposed through MSM and injection drug use.

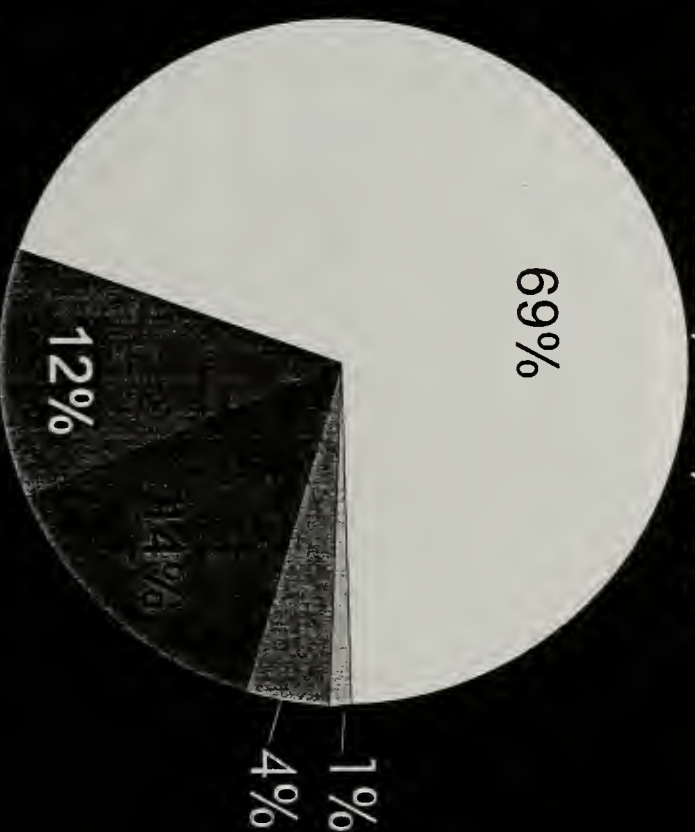


AIDS Cases Reported in 2001 and Estimated 2001 Population, by Race/Ethnicity, United States

AIDS Cases
N=43,158*



Population
N=289,282,000



White, not Hispanic
Black, not Hispanic
Hispanic

Asian/Pacific Islander
American Indian/
Alaska Native

*Includes 57 persons with unknown race/ethnicity



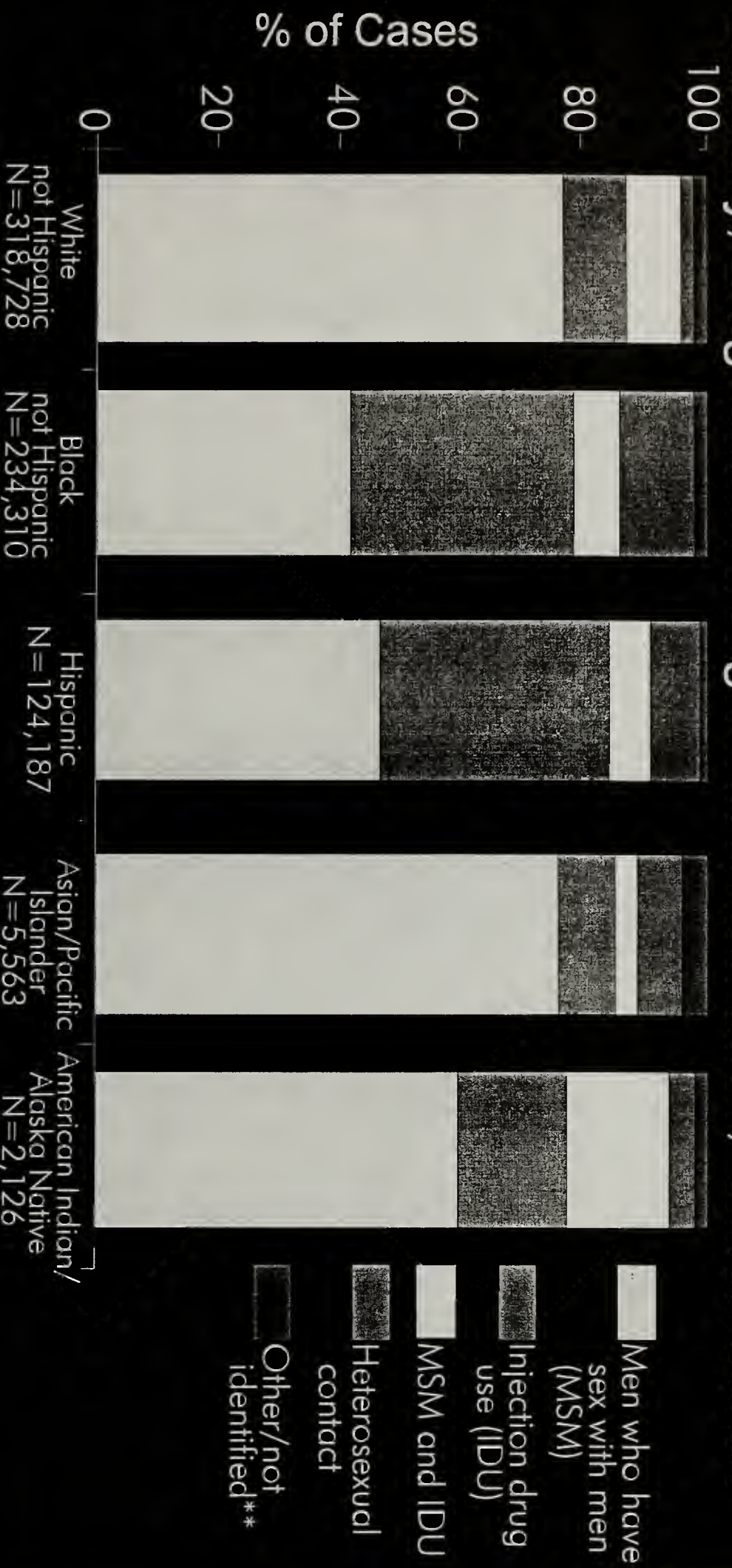
AIDS Cases Reported in 2001 and Estimated 2001 Population, by Race/Ethnicity, United States

In 2001, 43,158 cases of AIDS were reported to CDC. The distribution of cases among some racial/ethnic groups is disproportional to the distribution in the general population.

Of the cases reported, 31% were among white persons, whereas 69% of the population is white. A total of 49% of the cases reported were among black persons, yet only 12% of the population is black. And 19% of cases were among Hispanics, who represent 14% of the population. These differences reflect a combination of factors including prevalence of HIV, prevalence of risk behaviors, and access to and use of treatment that delays progression of HIV infection to the development of AIDS.



Estimated* Percent Distribution of AIDS Cases in Male Adults and Adolescents, by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States



*Data adjusted for reporting delays and estimated proportional redistribution of cases reported without a risk

**Includes patients with hemophilia or transfusion-related exposures and those whose medical record review is pending; patients who died, were lost to follow-up, or declined interview; and those with other or undetermined mode of exposure



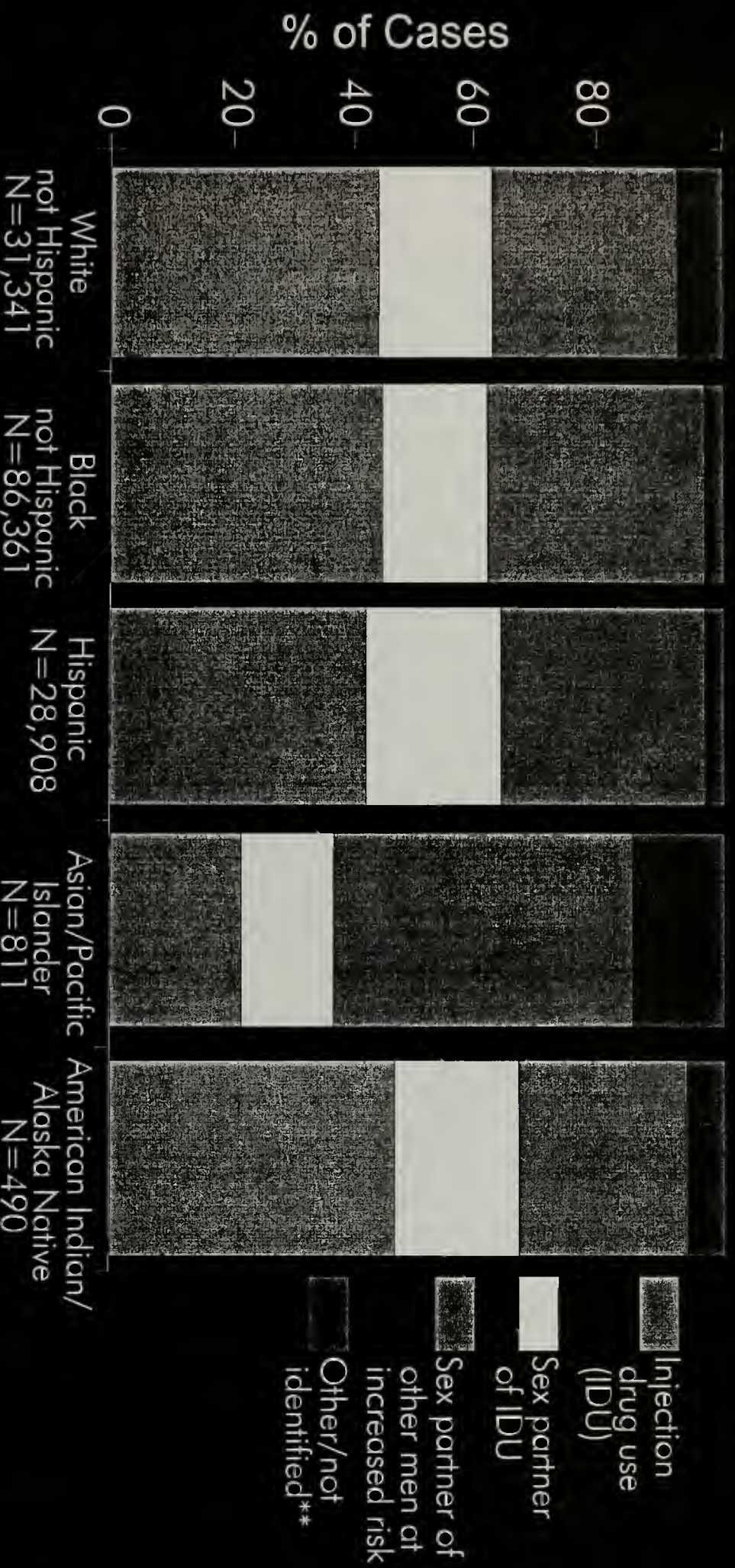
Estimated Percent Distribution of AIDS Cases in Male Adults and Adolescents, by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States

The mode of exposure to HIV differs by racial/ethnic group.

Among white men with AIDS, 77% were exposed through MSM and 10% were exposed through IDU. This distribution was similar among Asian/Pacific Islander men. Among black men, 41% were MSM and 37% were IDU. Among Hispanic men, similar proportions were exposed through MSM (46%) and IDU (38%). Among American Indian/Alaska Native men with AIDS, 59% were MSM, 17% IDU and 17% MSM who injected drugs.



Estimated* Percent Distribution of AIDS Cases in Female Adults and Adolescents, by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States



*Data adjusted for reporting delays and estimated proportional redistribution of cases reported with a risk

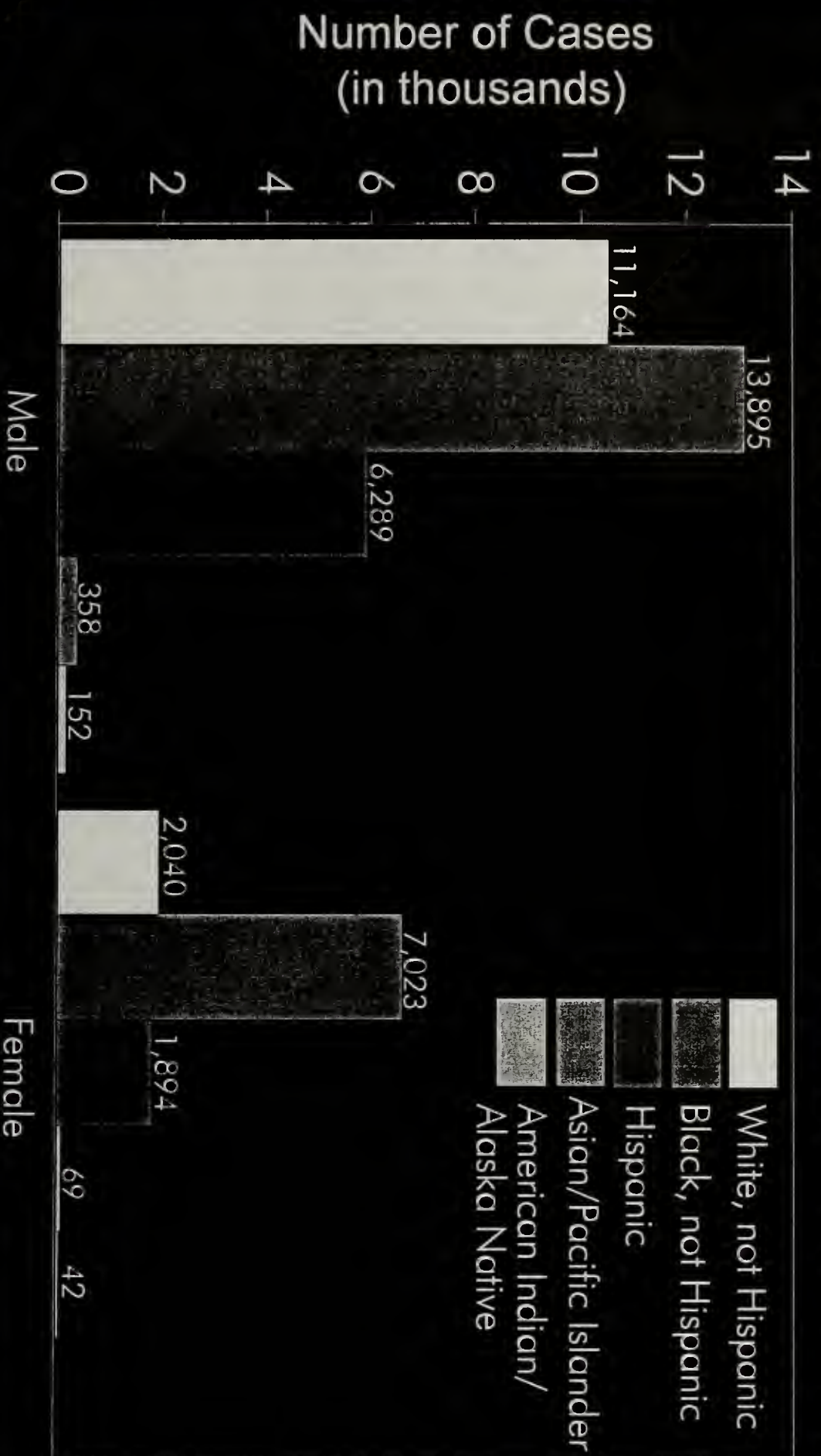
**Includes patients with hemophilia or transfusion-related exposures and those whose medical record review is pending; patients who died, were lost to follow-up, or declined interview; and those with other or undetermined modes of exposure

Estimated Percent Distribution of AIDS Cases in Female Adults and Adolescents, by Exposure Category and Race/Ethnicity, Diagnosed through December 2001, United States

Of the women and adolescent girls with AIDS, 44% were exposed to HIV infection through injection drug use (IDU) and 52% through heterosexual contact with an injection drug user, a bisexual male, a male with hemophilia, a transfusion recipient with HIV infection, or an HIV-infected person. These proportions were similar for white, black, Hispanic, and American Indian/Alaska Native women. Among Asian/Pacific Islander women, compared with other racial/ethnic groups, a higher proportion were exposed through heterosexual contact (63%), and fewer through injection drug use (21%).



AIDS Cases in Adults and Adolescents, by Sex and Race/Ethnicity, Reported in 2001, United States



Male
N=31,901*

Female
N=11,082*

*Includes cases with unknown race/ethnicity



AIDS Cases in Adults and Adolescents, by Sex and Race/Ethnicity, Reported in 2001, United States

In 2001, 74% of reported AIDS cases were among males. More AIDS cases among men were black, followed by white and about half as many were Hispanic.

Among women, 63% were black, and nearly equal numbers were white or Hispanic.

Relatively few cases of AIDS were reported among Asian/Pacific Islander and American Indian/Alaska Natives women in 2001.



BOOK DESCRIPTION

On Social Marketing: A Step-by-Step Guide

by Nedra Kline Weinreich

Have you ever read an article or emerged from a workshop, excited about using social marketing techniques in your own program, only to come back to the office and say, "Now what do I do?" And how often do people say, "We need to take a social marketing approach," without really understanding what that means and how to implement it? *Hands-On Social Marketing: A Step-by-Step Guide* will provide you with the practical skills you need to put social marketing to work for you.

Several excellent books on the art and science of social marketing provide theoretical knowledge about what social marketing is and the rationale for how and why to use it. For many, though, the jump from theory to practice is a precipitous leap of faith into uncharted territory rather than a step-by-step process of strategic planning and development. This book provides practical advice not offered by the more academic texts, gently guiding you in the development of a social marketing program from the beginning all the way through to evaluation and points beyond.

Hands-On Social Marketing was written with practitioners primarily in mind. Organizations at the community level may not have the benefit of extensive resources and expert assistance at their fingertips that are often found in state and national social marketing programs. Each chapter takes into account the challenges faced by organizations with small budgets and little experience with developing and implementing this type of program. Despite this orientation, the information in this book is equally applicable to those working at the state, national or international levels.

The beauty of social marketing is that it provides a clearly defined process for program development. This book explains that process and provides detailed advice on how to successfully accomplish each stage. Moreover, the book is designed to be user-friendly and functional -- a tool as much as a teacher. By using the many accompanying worksheets in your planning, you will have a ready-made "consultant" asking you all the right questions as you go along.

The main message of this book is that you can do social marketing yourself. You do not need to hire a high-priced advertising agency or spend large sums of money to put these ideas into practice. This book emphasizes low-cost research methods and tells how to stretch a small budget without sacrificing quality. The biggest investment you will need to make is mental not material -- it is simply to develop the understanding needed to begin thinking from a social marketing perspective.

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About the Author

Nedra Kline Weinreich is president of Weinreich Communications, a social marketing firm based in Los Angeles, California. Although the company itself was founded in 1995, Ms. Weinreich has long established herself as an expert in the fields of social marketing and health communications. She is the author of the well-received book "Hands-On Social Marketing: A Step-by-Step Guide" as well as the publisher of Social-Marketing.com. She is a sought-after speaker in the field, and has provided training and technical assistance to many organizations to assist them in putting social marketing into practice. Ms. Weinreich earned her Master's degree in Health and Social Behavior from the Harvard School of Public Health.

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Collaboration Partnership Content

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From the National Institute of Justice (<http://www.ojp.usdoj.gov/nij/>)

- 2 **Evaluation Collaboratives: Reaching the Potential**
http://cecommerce.uwex.edu/pdfs/G3658_8.PDF
From the University of Wisconsin Cooperative Extension (<http://www.uwex.edu/ces/index.cfm>)

- 3 **Creating Partnerships**
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- 4 **An A to Z of Partnerships**
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- 6 **Factors Influencing Collaborations**
From the National Network of Collaborations



National Institute of Justice Centers for Disease Control and Prevention

R e s e a r c h i n B r i e f

July 1998



Partners in Research on
Correctional Health Care

Issues and Findings

Discussed in this brief: The extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB, based on responses to the 1997 NIJ/CDC national survey of correctional systems and site visits to six States and five city/county jurisdictions.

Key issues: Correctional populations have higher rates of HIV/AIDS, STDs, TB, and more risk factors for these diseases than the general population. Virtually all inmates return to the community, where they may place themselves and others in danger by engaging in high-risk behaviors. Collaborations between public health and correctional agencies may help fill gaps in programs for the prevention and treatment of HIV/AIDS, STDs, and TB, thereby benefiting an at-risk and underserved population as well as overall public health.

Key findings:

- According to NIJ/CDC survey responses, virtually all correctional systems have at least some collaboration with public health agencies.
- Site visits identified numerous collaborations in disease surveillance, testing and screening, followup, education and prevention programs, staff training, treatment services, and legislation and policy development, but found fewer collaborations in discharge planning and transitional services for people being released.
- Most existing collaborations involve public health departments providing funds, staff, or direct services in correctional facilities.
- Programs in Rhode Island and New York State exemplify more comprehensive collaborations.
- Key factors in successful collaborations include:

Public Health/Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs, and TB

by Theodore M. Hammett, Ph.D.

The missions of public health departments and correctional agencies are highly complementary: Correctional facilities and inmate populations are part of the larger community, and public health is integral to public safety. Public health and correctional agencies are increasingly working together to improve the health of inmates and, at the same time, the health of the larger community.

More than 1.75 million people are incarcerated in the prisons and jails of the United States—close to 1 percent of the Nation's population.¹ Inmates suffer disproportionately from infectious diseases, substance abuse, and a constellation of socioeconomic problems. In particular, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), sexually transmitted diseases (STDs) (such as syphilis, gonorrhea, and chlamydia), and tuberculosis (TB) are far more prevalent among incarcerated persons than the general U.S. population.

Figures from a 1994 survey cosponsored by the National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC) (the NIJ/CDC survey) reveal that AIDS is almost six times more

prevalent among inmates than in the total U.S. population.² State and Federal inmates accounted for about 3 percent of the HIV-infected people in the country in 1995.³ Incidence rates of gonorrhea in 1994 were 152 times higher among confined juvenile girls and 42 times higher among confined juvenile boys than among girls and boys of equivalent ages in the total population.⁴ Comparisons are more difficult to make regarding TB, but the numbers in themselves are telling. Based on 1994 data from 31 State prison systems, the purified protein derivative (PPD) skin-test positivity rate (which indicates TB infection) among inmates was almost 14 percent, while 25 prison systems reported that more than 5,600 inmates converted from negative to positive PPDs in the 2 years prior to the NIJ/CDC survey.⁵ In addition, risk factors for these infections are much higher in incarcerated populations than in the population at large.

Adult inmates and confined juveniles represent a large, highly at-risk population that could benefit greatly from health interventions. Such interventions could also greatly benefit overall public health.^{6,7} Many correctional systems have

continued...

Issues and Findings

continued...

- Availability of data on disease burden or dramatic events such as outbreaks demonstrating the need for collaborations.
- Organizational, legislative, or regulatory provisions such as health department responsibility for provision of health services in correctional facilities; or legislation or regulations requiring oversight mechanisms, screening, or disease reporting.
- Attitudes and philosophies such as commitment to collaboration at agency and facility levels; correctional agency willingness to open its facilities to outside organizations; and mutual sensitivity to concerns, priorities, and perspectives of corrections and public health personnel.
- Health department funding of programs in correctional facilities and operational features such as the presence of health department personnel in correctional facilities, liaison staff in correctional and public health agencies, formal agreements for collaboration (such as MOUs), and long-standing inter-agency relationships.
- Communication and information exchange such as correctional representation on HIV Prevention Planning Groups, service on joint committees, regularly held meetings at leadership and operational levels, and the exchange of important information about patients.

Recommendations: The key recommendations of the NIJ/CDC study involve implementing the following four key facilitators of collaboration:

- Public health agency collection and dissemination of data on the burden of infectious disease in inmate populations.
- Including correctional representation on all HIV Prevention Planning Groups.
- Public health agency initiation or expansion of funding for services and staff in correctional facilities.
- Public health and correctional agency recognition of the importance and potential benefits of interventions in correctional settings to the health of the larger community.

Target audience: Correctional administrators, public health agency administrators, correctional health services staff, public health agency staff, and legislators and other policymakers concerned with public health and criminal justice.

responded to this need and opportunity by instituting a variety of these interventions. However, the 1997 NIJ/CDC survey results reveal that numerous gaps remain. Less than two-thirds (61 percent) of State and Federal correctional facilities were providing instructor-led HIV/AIDS sessions, and only 13 percent were providing peer-led programs.⁸ Other areas of insufficient services include discharge planning and continuity of medical services from correctional facilities to the community. Overall, more coordination is needed between services in these two domains.

Survey and Site Visit Methodologies

The ninth national NIJ/CDC survey of HIV/AIDS, STDs, and TB in correctional facilities was conducted in 1996 and 1997. Responses were received from all 50 State departments of correction, 41 of the largest city/county jail systems, and the Federal Bureau of Prisons. Following that, the survey was validated using an abbreviated version of the questionnaire with 50 individual facilities in 15 State correctional systems and the Federal Bureau of Prisons. The objective of the validation was to compare responses on key policy issues from individual facilities with responses from the central offices of their State departments of corrections.

As a followup to the national NIJ/CDC survey, a series of 11 site visits also was conducted in 1997 to determine the extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB.

Site visits were made to the following 6 States and 5 city/county-level jurisdictions by teams from Abt Associates, the Centers for Disease Control and Prevention, and the National Institute of Justice:

- States
 - Florida.
 - Illinois.
 - Missouri.
 - New York.
 - Rhode Island.
 - Washington.

Collaborations between public health and correctional agencies represent a potential means of filling these and other gaps in health-related services for inmates. Public health departments may have the funds, staff, expertise, and other resources to help prisons, jails, and juvenile facilities address the serious health needs of their inmates and thereby advance the cause of public health in their communities.

Consistent with their overall public safety and security missions, prisons and jails

- Cities and Counties
 - San Francisco, California.
 - Chicago (Cook County), Illinois.
 - Rochester (Monroe County), New York.
 - Memphis (Shelby County), Tennessee.
 - Houston (Harris County), Texas.

The sites were chosen based on telephone interviews with more than 20 jurisdictions that had been identified by CDC and Abt Associates. The final site selections were made with a view toward geographic diversity and having an even mix of State and city/county jurisdictions.

The 2-day visits included interviews with correctional and public health staff as well as visits to correctional and juvenile confinement facilities. Key public health staff in HIV/AIDS, STDs, and TB and correctional health services staff and others in the correctional systems who were involved in collaborations with public health departments were interviewed. The study team visited the major jail facility in each city/county and one or two facilities in each State.

Exhibit 1: Collaboration Between Correctional Systems and Public Health Departments, 1997

Percentage of Systems Reporting Collaborations

Areas of Collaboration	HIV/AIDS		STDs		TB	
	State/Federal Prison Systems (N=51)	City/County Jail Systems (N=41)	State/Federal Prison Systems (N=51)	City/County Jail Systems (N=41)	State/Federal Prison Systems (N=51)	City/County Jail Systems (N=41)
Educational Programs	78	63	67	53	75	49
Other Prevention Programs	69	59	55	39	61	41
Testing/Screening	73	68	69	73	71	71
Case Reporting	90	66	92	59	92	85
Counseling	78	61	53	46	47	37
Partner Notification	75	44	78	59	78	54
Outbreak Investigation	51	37	61	44	82	73
Treatment/Prophylaxis	65	59	65	63	80	85
Discharge Planning	84	71	65	54	84	83
Staff Training	82	68	73	59	82	76

Source: 1997 NIJ/CDC Survey

can create opportunities for interventions with underserved populations who are at high risk for HIV/AIDS, STDs, and TB. Correctional administrators can provide access to these populations and otherwise facilitate interventions by including language requiring early disease detection and treatment in their health protocols. Such language may be particularly important where health services are being provided through contracts with private organizations.

The study described in this report examined the extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB. A description of the methodologies used for the survey and the site visits is found in "Survey and Site Visit Methodologies."

As expected, the study revealed that State health departments collaborated primarily with State correctional agencies, while city and county health departments worked primarily with county jails. However, there were numerous interactions between State health departments and county jails.

In addition, collaborations between State correctional systems and county jails were very important, but sometimes inadequate, particularly in the area of information exchange.

The study occasionally touched on collaborations between corrections and other entities such as community-based organizations (CBOs) and academic medical centers. Indeed, a range of potential collaborators could be identified for future program development and research efforts.

This report first summarizes collaborations reported to the 1997 NIJ/CDC survey and those identified during site visits for this study. Two brief case studies are then presented, followed by a discussion of the factors important in successful collaboration. The report concludes with policy implications for improving and expanding collaborations.

Diversity of collaborative efforts

Collaborations between public health and correctional agencies encompass a wide variety of activities in the prevention and treatment of HIV/AIDS,

STDs, and TB (see exhibit 1). Responses to the 1997 NIJ/CDC survey of correctional systems show that collaborative efforts are common and wide ranging. Virtually all State and Federal prison systems (98 percent) and city/county jail systems (90 percent) reported some collaboration with a public health department in the surveillance, prevention, and treatment of HIV/AIDS, STDs, or TB.

The appendix (pages 16 and 17) summarizes the diverse collaborative efforts identified during the site visits to 11 jurisdictions within the following broad headings:

- Administration and infrastructure.
- Policy development.
- Service delivery.

Many collaborations exist in disease surveillance, staff training, legislation and policy development, education/prevention programs, testing/screening/followup, and treatment services, as shown in the appendix. However, there are relatively fewer collaborations in quality assurance, clinical protocol de-

R Rhode Island's Model of Collaboration

Rhode Island has developed a state-of-the-art model of collaboration involving the State Department of Health, the State Department of Corrections, an academic medical center (Miriam Hospital, affiliated with Brown University), and approximately 40 community-based organizations and service agencies. The organizational chart of Rhode Island's AIDS Services After Prison (ASAP) program, a centerpiece of the State's collaborative efforts, is displayed in exhibit 2.

Meetings and interactions between all of the organizational partners in the Rhode Island collaboration take place regularly. The partners also work together on disease surveillance, policies, legislative proposals, and union issues in the facilities. There is a demonstrable commitment to working together. In the words of the administrator of the Rhode Island health department's office of HIV/STDs, there is no sense of "our problem versus your problem."

The Department of Health provided much of the initial funding for staffing the program. However, over time, the program has been institutionalized and the Department of Corrections has picked up an increasing share of personnel costs, funding two public health educator positions from its regular budget.

In 1986 collaboration between the Rhode Island health and correctional departments led to the development of one of the first correctional AIDS policies in the United States. Early on, treatment and supportive services for inmates with HIV and continuity of care between pro-

viders in prison and in the community were important goals of this collaboration.⁹ Subsequently, pretest and posttest counseling, discharge planning, transitional services, and community linkages for HIV-infected inmates and at-risk HIV-negative inmates were added.

The legislatively mandated implementation of HIV-antibody testing for incoming inmates in 1989 and the expansion of TB and STD screening in Rhode Island correctional facilities provided data that made a compelling case for health programming. The correctional department completes surveillance reports on HIV, STDs, and TB and provides those reports to the health department. The correctional department also notifies the health department's TB unit when a person with active or suspected TB or on TB prophylaxis is being released so continuity of care can be arranged.

Postrelease services for inmates with HIV infection or at risk for HIV infection include medical treatment, housing, substance abuse treatment, job development, psychosocial support, and long-term case management.¹⁰ Evaluation results reveal reduced recidivism rates among female inmates who participated in these programs.¹¹ Compliance with postrelease medical and other appointments for services increased dramatically as well.

Program staff participate in a weekly case-assignment meeting to discuss community linkages and placements for inmates nearing release. Four key community-based organizations that specialize in the following populations and services participate in these

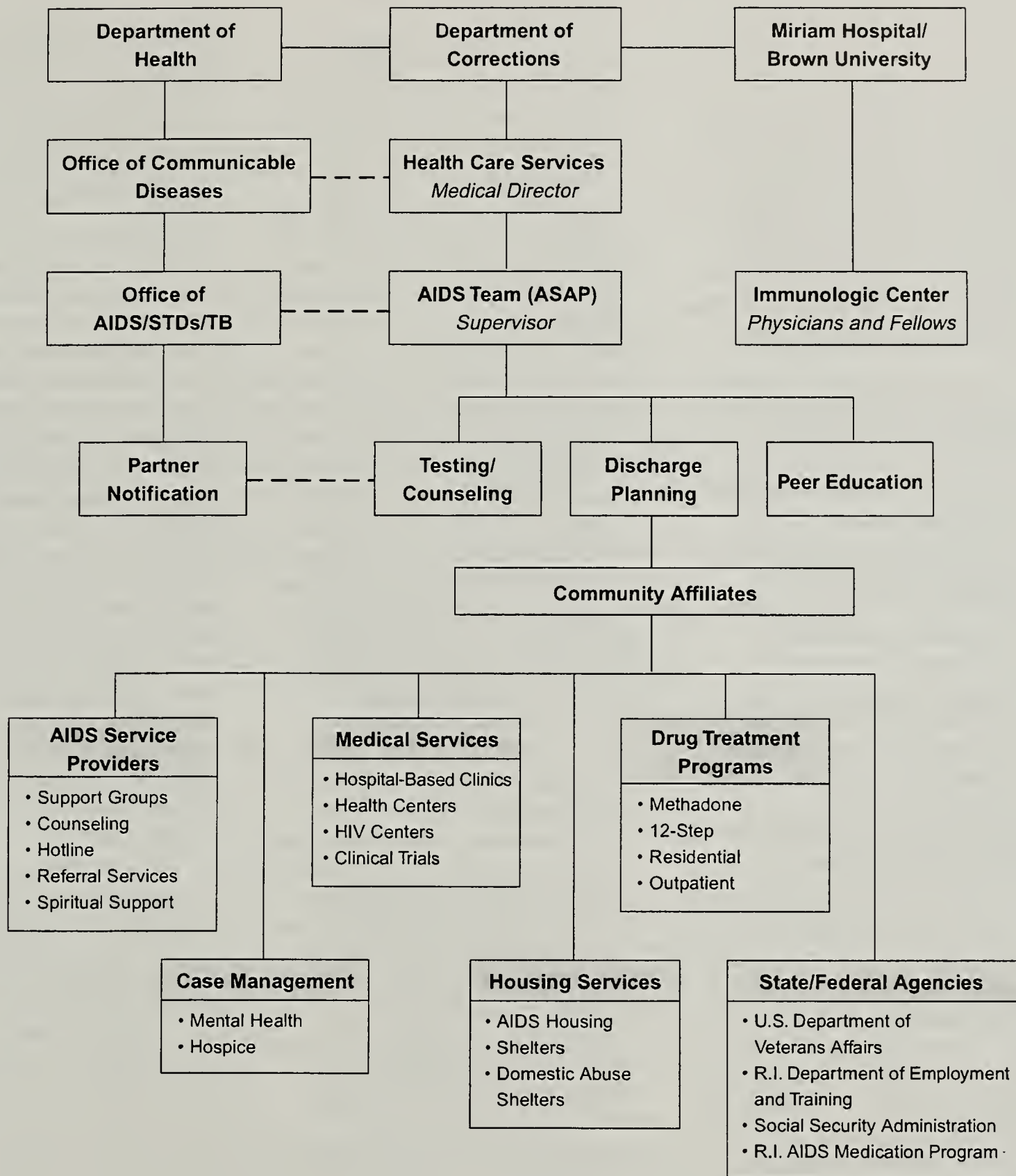
meetings: 1) mentoring for employable women; 2) services for cocaine- and/or alcohol-involved persons; 3) services for long-term sex workers and/or injection drug users; and 4) services for HIV-infected persons.

A disease investigation specialist, whose position is funded by the Department of Health and who is based at the correctional facility, notifies inmates' sexual partners and performs outreach, primarily HIV. The specialist also locates HIV-positive individuals who have been released to the community before receiving their test results and links them to services at Miriam Hospital or a comparable provider of HIV services.

The CDC funding of two additional public health educator positions in the Department of Corrections has increased the overall program's emphasis on prevention. These educators orient incoming inmates on infectious diseases, provide multisession prevention programs for current inmates and educational sessions for staff, and coordinate inmate peer education programs.

Health department staff have met with the correctional officers' union to address issues surrounding disclosure of inmates' HIV status. The union favored disclosure to all correctional officers, but a compromise was achieved whereby disclosure may occur only in the case of potential transmission incidents, which are the primary concern of the union.

Exhibit 2: Rhode Island AIDS Services After Prison (ASAP) Organizational Chart



velopment, discharge planning/transitional services, and laboratory services. Most of the collaborations identified in this study involve public health departments providing funding, staffing, and services to correctional departments. In order to succeed, such arrangements require interaction and cooperation between public health and correctional agencies as well as access to inmate populations. However, some collaborations go well beyond health departments providing services in prisons and jails. See "Rhode Island's Model of Collaboration" and "New York State's Model of Collaboration" for brief case studies of two such collaborations.

The following factors are common to successful collaborations between public health and correctional agencies:

- Data and events demonstrating a need for collaboration.
- Organizational, legislative, and regulatory provisions.
- Appropriate attitudes and philosophies.
- Program funding and operations.
- Communication and information exchange.

Data and events demonstrating a need for collaboration

Successful public health/corrections collaborations are much easier to develop and sustain when *data documenting the burden of disease* in the inmate population are readily available. Some might suggest that such data are a prerequisite for successful collaborations. Public health departments could be more proactive in disease surveillance among corrections populations. Better surveillance might produce a whole series of positive effects: more resources for correctional

health programs, better services, a safer and healthier environment for inmates and staff, less disease returned to the community, and ultimately improved public health.

In Rhode Island, for example, the health and correctional departments demonstrated that 42 percent of all new HIV infections in the State were identified in correctional facilities. This convinced the State's HIV Prevention Planning Group to endorse substantial continued funding of collaborative HIV programs in prisons. Until these data were available, the planning group had expressed skepticism about the value and importance of prison-based programs. In Florida, data showing that 13 percent of the State's syphilis morbidity was identified in correctional facilities served as an important impetus for collaborative STD screening programs. In Washington, the State health department documents and publishes periodic reports on STD morbidity in adult and juvenile facilities, which helps justify the department's continued involvement in STD screening and followup programs in these facilities.

Because of low success in locating people released from Cook County Jail before syphilis treatment could be given, a rapid screening and treatment program for women in the jail was initiated. As a result, the percentage of Chicago's total syphilis morbidity identified at Cook County Jail increased from 17 percent in 1995 to 24 percent in 1996. The rapid screening and treatment program is a collaborative effort of CDC, the Chicago Department of Health, and the Cook County Jail.

Without hard data on the incidence and prevalence of HIV/AIDS, STDs, and TB, it is much more difficult to interest correctional and health departments in

collaborating on interventions. It is more difficult to justify requests for funding and other resources if the scope of the problem is unknown or undemonstrated. In some jurisdictions visited for this study, for example, jail medical services and public health department staff have no clear picture of morbidity among the inmates. The lack of this information is, in their view, a major stumbling block to more effective and better supported collaboration.

Dramatic events may call attention to the need for collaboration. For example, concern raised by the 1991 outbreak of multidrug-resistant TB in New York State and by other local outbreaks was mentioned in a number of jurisdictions as a factor promoting collaboration between public health and corrections. The New York outbreak prompted the formation of a city/county TB task force in Chicago.

In New York State, health department involvement in TB interventions that helped to protect correctional staff smoothed the way for other collaborations on HIV/AIDS and STDs. Staff in several jurisdictions identified collaborations in TB prevention, with their strong employee protection focus, as the "foot in the door" for other collaborative efforts.

Organizational, legislative, and regulatory provisions

In San Francisco and Memphis *the health department is responsible for providing health services in the correctional facilities*. Such arrangements require interaction and may help foster fuller collaboration. In San Francisco, for example, the director of forensic services, the health department unit responsible for jail health services, sits on several committees with sheriff

department staff and, in turn, involves custody staff in health services committees. Nurses also meet regularly with custody captains to address issues in health services delivery.

Another important factor promoting collaboration is *legislative and regulatory provisions*. Strong State legislation in New York called for establishment of an interagency AIDS task force, which required that the commissioners of the State health and correctional departments and other agencies coordinate efforts in criminal justice settings. California law requiring notification to health departments of all TB cases was a spur to collaborations with correctional systems in the development of reporting procedures. Also in California, the legislatively created State Board of Corrections has the power to regulate local and county jails. The board's regulations require that each jail has a communicable disease control plan jointly created by jail officials and the local health officer. A Texas law enacted in 1993 requires all jails with 100 or more beds to submit TB control plans to the local health department.

The Memphis-Shelby County health officer used the powers granted him under Tennessee law to mandate PPD screening for TB in jails. Indeed, the jail director also favored PPD screening but asked the health director to require it in order to provide stronger justification and gain the cooperation of jail staff. A 1988 Washington State law provides for court-ordered HIV testing of inmates involved in potential transmission incidents, as well as convicted injection drug users, sex offenders, and sex workers. The correctional and juvenile agencies sought and obtained the involvement of the State health department in providing this mandated testing and reporting its results.

Attitudes and philosophies

Three important attitudes and philosophies of key actors in public health and corrections systems appear to facilitate successful collaboration:

- Strong commitment.
- Willingness to open facilities to outside agencies.
- Sensitivity to the concerns of both corrections and public health.

At the level of agency and facility leadership, there must be a *strong commitment* to collaborative approaches. This may involve a realization and declaration that infectious diseases among inmates represent both a correctional and a public health problem. As the county jail director in Memphis emphasized, public health is a part of the public safety that correctional facilities exist to protect. The Florida Department of Corrections' assistant secretary for health services stated that "the health problems of our inmates are public health problems because inmates go back to the community." In Illinois, the director of the correctional department endorsed an inmate peer education program sponsored by the health department and wrote to all facility superintendents encouraging their cooperation.

Correctional officials' commitment to collaborative approaches generally leads to their *willingness to open their facilities to outside organizations*. This is not always easy for correctional administrators to do, in view of their primary concern with security. They may also be wary of outsiders, based on their perceptions or experiences that outsiders' main purpose is to find and expose fault in correctional facilities. Even when central office leaders in a correctional system direct that there

be open collaboration, individual superintendents may still attempt to prevent it in their facilities.

Numerous superintendents, however, are open to the involvement of outside agencies. Some, like the warden of Rhode Island's women's facility, see such involvement as essential. She welcomes outside medical providers, community-based organizations, student interns, and others to her facility. She believes that prisons are part of the community and that there should not be "impenetrable walls" between them. Moreover, she believes that outside providers are helpful to inmates in making transitions back to the community.

If correctional and public health agencies are to work together successfully, they must have *sensitivity to each other's concerns*. It is important, for example, that public health staff understand that security is, and always will be, the first priority of correctional systems. Public health activities must be accommodated within the overall correctional structure and procedures. As a public health investigator from the Houston health department's TB section commented, one must "ease in," work with security staff, abide by their rules, and try to build one-on-one relationships. Taking this approach, this public health investigator was accepted as "one of them [the deputies]" and enjoys their full cooperation. Similarly, the San Francisco health department's TB control staff person working in the jails has achieved good cooperation from custody staff by "requesting rather than demanding" assistance. In Washington State, the correctional department credited health department staff with being extremely collegial, focusing on finding solutions rather than finding fault.

C New York State's Model of Collaboration

Collaborations between the New York State Department of Health (DOH) and the Department of Correctional Services (DOCS) on HIV/AIDS and TB involve almost constant interaction between the two agencies at both central office and facility levels. Collaborations on STDs have been primarily between DOH and county jails because DOH staff believe that the key opportunity for STD intervention is at the jail level and is essentially lost once inmates move on to DOCS facilities.

Beginnings of collaboration. The AIDS Institute of the New York State DOH and DOCS began their collaboration in 1987. The institute's Criminal Justice Initiative (CJI) involves a comprehensive array of HIV/AIDS services in DOCS facilities, such as HIV counseling and testing, education (including peer education programs provided by ex-offenders and current inmates), and supportive and transitional services for inmates living with HIV disease.

Facility-level cooperation. Institute staff emphasize that their involvement has been and remains dependent on the cooperation of individual facilities' superintendents, which, with the substantial assistance of DOCS central office staff, they have been quite successful in winning and maintaining.

State-level cooperation. The DOH Bureau of HIV/AIDS Epidemiology (AIDS Epi) and DOCS have collaborated on HIV/AIDS surveillance. The AIDS Institute and DOCS have also collaborated on the development of medical protocols and a quality review of HIV medical services. A memorandum of understanding between DOCS and the AIDS Institute for ongoing case-based quality review of HIV medical services was under development at the time of the site visit.

In 1989 the AIDS Institute and DOCS initiated a joint project in which DOCS funded positions in the institute to form regional teams to provide HIV counseling and testing for inmates and educational programs for inmates and correctional staff. This project was closely coordinated by the central offices of both agencies, and DOCS reviewed and approved the educational curriculums. Funding was also provided for AIDS Counseling and Education (ACE), a peer-based prevention and support program at the Bedford Hills women's facility. In 1992, the Women's Prison Initiative was established by the AIDS Institute to replicate the ACE peer education model at the other women's facilities and to provide a comprehensive continuum of care for HIV-infected females. Services provided at Albion, Taconic, and Bedford Hills correctional facilities include peer training, peer-delivered education on HIV/AIDS prevention and risk reduction, HIV counseling and testing, supportive services for HIV-infected inmates, and discharge planning and case management for inmates with HIV disease.

The AIDS in Prison Hotline project, funded by the AIDS Institute and operated by the Osborne Association in New York City, provides counseling, education, support, and referrals to community-based services for inmates. Inmate collect calls are encouraged.

CBOs brought in. In 1993 the regional teams serving DOCS facilities were expanded to include community-based organizations (CBOs). DOCS, CDC, the AIDS Institute, and other sources provide about \$3 million per year for CJI activities. Most DOCS facilities now receive services through the AIDS Institute's CJI.

AIDS Institute staff reported that relations between the regional teams, the CBOs, and DOCS central office and facility staff are generally good. Although only about 25 percent of the funding for CJI activities

comes from DOCS, interdepartmental communication and collaboration at the central office level are essential. At the facility level, the regional teams and CBOs are often accepted as part of the facility's staff. Initial and ongoing meetings on AIDS Institute programs at the facility level help ensure mutual understanding of roles and expectations and address emerging issues. Correctional officers' union representatives and inmate liaisons are included in these meetings.

HIV-seroprevalence studies. In the late 1980s, AIDS Epi began collaborating with DOCS on a series of blinded studies of HIV seropositivity among incoming inmates at the reception centers—Downstate and Ulster for men, and Bedford Hills for women. When it became clear that HIV seropositivity rates among inmates accepting voluntary testing were substantially lower than rates found in the blinded studies, the AIDS Institute and DOCS collaborated on a pilot study at Ulster to investigate these discrepancies. The 1994 study revealed that many inmates did not accept voluntary testing because they denied or underestimated the seriousness of their risk factors. Prior knowledge of HIV status was not a major reason for inmates to decline voluntary testing.

AIDS reporting extended. AIDS surveillance for DOCS inmates was essentially passive until 1996; inmate cases were not reported to DOH by DOCS. Only inmates admitted to a hospital for an AIDS-related illness were reported. In 1996, however, DOCS began providing DOH with an electronic database of case reports for all inmates known to have AIDS. This facilitated cross-checking case registries and helped increase the accuracy of case counts.

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New York State's Model of Collaboration

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Success in TB control. Since 1988, the New York State DOH Bureau of TB Control and DOCS have had extensive and, according to DOH staff, "exemplary" collaborations in screening, treatment, case management, surveillance, outbreak investigation, discharge planning, education and training of staff and inmates, and technical assistance to staff. TB cases in DOCS have declined steadily since reaching a peak in 1993. No TB outbreaks have occurred in DOCS facilities since 1993.

In 1988 and 1993, the New York State DOH's Bureau of Occupational Health assessed air-handling systems in DOCS facilities to better control TB. Training in environmental infection control measures and monitoring of negative pressure rooms was also given. DOH staff worked closely with DOCS and CDC staff to investigate and respond to a 1991 outbreak of multidrug-resistant TB. This included development and implementation of mandatory annual inmate and staff screening, education and training, and other measures to prevent recurrent outbreaks of TB.

HIV-related TB project. From 1991 to 1995, DOH collaborated with DOCS on the HIV-Related TB Project (H RTP). This established a demonstration screening and directly observed preventive therapy program at DOCS intake facilities. DOH conducted TB surveillance at DOCS facilities, and DOCS carried out all screening and treatment of inmates.

Two public health representatives (PHRs) from the DOH Bureau of TB Control are based at a DOCS reception center, where they are well integrated with health service staff. Another eight PHRs collectively visit each prison every 2 weeks to identify and report new suspected cases of TB and monitor treatment. In general, the PHRs work closely with the DOCS infection control nurses at the prisons on TB control, screening, and treatment issues. DOH staff conduct all surveillance and case tracking and consult on contact investigations and case management in DOCS facilities. PHRs report possible AIDS cases they identify to the AIDS Epi staff at DOH. The process of completing clinical records is automated so the appropriate PHR can be notified and receive case records immediately when an inmate is transferred to a facility in a different part of the State. Regular meetings and interactions

between DOH and DOCS staff are devoted to surveillance, including reconciliation of case counts and other matters. DOH's TB nurse coordinator meets every 2 weeks with the DOCS director of communicable disease control who supervises the infection control nurses in the prisons. DOH's TB Bureau works with DOCS and the parole department on discharge planning for inmates with TB, as well as on community linkages and monitoring of adherence to treatment regimens following release.

STD control in county jails. As mentioned, collaborations on STD services have largely occurred between the State health department and county jails. In a demonstration project funded by CDC at the Nassau County jail, DOH staff provided rapid syphilis screening at intake and treatment of inmates with positive tests and no record of prior treatment. This intervention had a significant and positive effect on syphilis morbidity in the overall community. The STD control division of DOH is working on similar programs with jails in Monroe, Westchester, and Chautauqua counties, as well as in New York City.

Showing a willingness to compromise on policy issues is another way to demonstrate mutual concern and sensitivity. For example, the director of forensic services in the San Francisco health department compromised with the sheriff's department on the implementation of a State referendum on disclosure of inmates' HIV status to correctional officers. The compromise carefully restricted recipients of the information and provided for coding of the information to minimize the possibility of unauthorized disclosure.

Counterproductive factors. While the factors elucidated above can help facilitate successful collaborations, it is important to realize that there are *real differences between the philosophies, perspectives, and priorities of public health and correctional agencies that can make collaboration difficult if they are not sensitively handled*. For example, the medical staff in the jail may align with security staff rather than with public health staff. In Rochester/Monroe County, New York, health department staff reported that when they first began providing services in the jail, there

seemed to be a "clash of cultures" between them and jail health staff. Since that time, however, a mutual respect for the different perspectives and challenges of each organization has led to collaborative and collegial relations. In Rochester, important improvements were made after a public health nurse spent time in the jail observing the work of her counterpart on the jail health staff. Through this experience, the public health nurse gained an appreciation of the danger, stress, and other challenges of working in the jail and developed great respect for the jail health staff.

The focus of the jail health staff is on emergency medicine and providing needed care within the context of maintaining safety and security. Public health activities and objectives such as disease tracking and followup are not as high a priority for jail health staff. By contrast, the health department staff who work in the jail place their highest priority on proactive public health activities such as screening, disease tracking, followup, and research. Nevertheless, the Rochester experience demonstrates that through mutual understanding, common ground can be discovered and effective collaborations achieved.

To be successful in the correctional environment, health department staff need to be able to work within the system and the rules. They cannot be confrontational and demand cooperation and then expect to succeed. According to the assistant health director in the Rochester health department, staff should beware of becoming inmate advocates and denouncing the system. Rather, they should focus on advancing the overall public health.

The director of medical services at the county jail in Houston described the differing perspectives by using the metaphor of a spoked wheel. To health services and public health staff, everything revolves around providing patient care and addressing health issues. To correctional staff, in contrast, health issues represent only one spoke of the wheel.

Lack of mutual respect and sensitivity can undermine collaborations. For example, health services and public health staff should not dismiss or ignore the concerns of correctional staff regarding occupational exposure to HIV and other diseases. As long as

these concerns are based on actual risk of transmission, they should be addressed with respect and seriousness. Correctional officers' unions are often in the forefront on issues of occupational risk. These unions may oppose inmate peer education programs or other programs that involve ex-offenders entering jail facilities. A willingness to take these concerns seriously and to be open to compromise on them is essential. In New York State, a compromise was reached that allowed ex-offenders to present educational sessions for inmates but not for correctional staff.

Collaborations also suffer if public health staff devalue the skills and expertise of correctional medical staff and other correctional staff. In several jurisdictions, correctional health care staff reported being treated with disrespect by health department personnel. At one facility, the health services staff employed by the correctional department resent what they view as an *inappropriate supervisory and oversight approach taken by State health department staff who come into the prison*. In other words, the correctional health services staff want acknowledgment of and respect for their expertise—instead of concern that they will not perform properly unless closely supervised. The nurse administrator at this facility declared that “until you treat people as equals, you can’t collaborate; you can only dictate.” At the central office level in this jurisdiction, key health services staff expressed concern about language suggesting similar suspicious assumptions that was included in proposed terms of a memorandum of understanding between the departments of health and corrections.

Health services staff of several other State correctional systems reported county

health department personnel, stigmatized them as inferior practitioners who could not find jobs elsewhere, demanding cooperation, and refusing to work within correctional rules and regulations.

Conversely, *obstructionism and lack of cooperation by correctional staff can undermine collaborative efforts*. For example, security staff may hinder inmates' access to health services. In one jurisdiction, it was reported that the correctional officers who prepared the sick-call lists sometimes allegedly denied access to inmates needing services. Gate-clearance problems sometimes also allegedly have made it difficult for health department staff to provide services efficiently.

Program funding and operations

The following funding and operational factors were found to facilitate collaboration:

- Health department funding of programs in corrections.
- Presence of health department staff and programs in correctional facilities.
- Presence of a liaison person.
- Formal agreements for collaborations.
- Staff characteristics.
- Longstanding relationships.

Funding by health department.

Funding is almost always a facilitating factor in collaborations. The director of medical services at the county jail in Houston said that collaboration could be based on the health department's ability and willingness to fill and pay for gaps in services and expertise. In Rhode Island, the health department provided much of the initial funding for the collaborative HIV/AIDS programs in the correctional facilities. The Department of Corrections was

subsequently able to institutionalize the program and bring some of the costs into its budget.

In contrast, perhaps the most pervasive barriers to collaborative efforts are inadequate funding and resource constraints. Even the most powerful arguments for public health interventions, no matter how well grounded in data, may be denied adequate support in the current political climate emphasizing the punitive over the rehabilitative functions of corrections. Most of the collaborative programs observed in this study were working under serious constraints on funds, staff, and space. In one jurisdiction visited, the public health department suggested that jail health staff resisted more aggressive screening for HIV and STDs because sufficient funds were not available to treat all the patients who might be diagnosed.

Physical plant and staffing. One jurisdiction reported that *no infrastructure or space* was available in the city jail to expand disease screening and offer other health services in which the health department might collaborate. In addition, staffing shortages at this same city facility would prompt resistance to escorting inmates to health services even if such health services were available. A jail director interviewed for the study acknowledged that the staff and facilities were inadequate to support more proactive health services.

Public health staff working in several other correctional facilities reported *frequent problems with the callout and escort of inmates* to attend medical services. These problems were attributed to a combination of staff shortages and obstructionism or lack of interest on the part of security staff.

Presence of public health programs. The *physical presence of public health programs* and staff in correctional facilities has promoted—in many cases, necessitated—collaboration. As described earlier, jail teams and staff from public health departments regularly work in the correctional facilities of the jurisdictions visited for this report, performing a variety of functions including screening, surveillance, education and training, contact investigation and partner elicitation, and followup.

Liaison. A *liaison* at the central office or facility level often makes collaboration easier to manage and sustain. In New York State, each facility has designated a single liaison for State health department programs—usually the nurse administrator or deputy superintendent for programs. This individual arranges gate clearances, sets up appointments, and ensures inmate access to services. In Illinois, the department of corrections' public health coordinator serves as the liaison for all health department programs and helps the programs gain acceptance at the facility level. A similar correctional liaison to the State health department in Florida has proven to be very useful.

Formal agreements. Embodying collaborations in *formal agreements* has been helpful in several jurisdictions. Memorandums of understanding (MOUs) and similar instruments help to institutionalize collaborative efforts, making them less dependent on personal relationships. Rhode Island's broad-based HIV/AIDS collaborations involving the health and correctional departments, an academic medical center, and numerous CBOs are formalized in written agreements.

From 1990 to 1996, the New York State Department of Health had an MOU

with the Parole Division to provide transitional services for HIV-infected inmates. Because the covered services were rolled into other contracts awarded in 1997, the MOU was not renewed. An MOU with the Division for Youth covering education, counseling, and testing services is still in place.

In Washington State, MOUs between the health and correctional departments and the juvenile agency specify roles and responsibilities regarding court-ordered HIV testing.

Other documents can also formalize collaborative efforts. For example, the strategic plan of the Florida department of corrections requires collaboration with the health department and other community resources.

Staff characteristics. In several visited jurisdictions it appeared that certain *staff characteristics* make collaborations easier to forge and maintain. For example, in Houston, both the director of medical services in the county jail and the supervisor of the health department's jail team mentioned that having a security background was useful for jail health services staff. The health department's jail team supervisor worked in corrections and criminal justice before assuming his current role and noted that this background helped him both negotiate the jail system and win quicker acceptance from security staff. The director of medical services in Houston worked for many years in security before taking his present position. He believes that when the director of medical services is a sheriff's department employee rather than an employee of another agency or a contracted organization, he or she has more leverage and authority to advance public health objectives in the jail setting.

In both New York State and Illinois, the key liaison to the health depart-

ment in the correctional department previously worked for the health department. This background helped the liaison not only to understand and commit to a public health approach but also to develop working relationships with health department staff more easily.

Relationships. Finally, *longstanding relationships* and the passage of time often are required to perfect collaboration. In Washington State, for example, the health and correctional departments were at one time part of the same State agency, so they have a long history of working together. In Rhode Island, the collaborative HIV/AIDS program was developed and refined over a period of 10 years.

Communication and information exchange

Opportunities to discuss issues and exchange information are important to developing and sustaining collaborations. The study identified four factors that improve communication and information exchange:

- Correctional representation on HIV Prevention Planning Groups.
- Health and correctional department service on other joint committees.
- Regular meetings at leadership and operational levels.
- Exchange of important patient information.

Representation on planning groups. Correctional representation on *HIV Prevention Planning Groups* is the most important factor in this category. These groups are mandated by CDC in all States and cities receiving CDC HIV prevention funds. The Prevention Planning Groups often have

substantial influence on the allocation of HIV prevention funding.

In Rhode Island, a correctional staffer is a member of the State's Prevention Planning Group. In San Francisco, a representative of the health department's Forensic AIDS Project, which provides HIV prevention programs in the jails, serves in the HIV Prevention Planning Group.

In Chicago/Cook County, a representative of the city health department's STD program (who was an advocate for correctional needs) serves in the HIV Prevention Planning Group. This representative presented jail data to the planning group and successfully lobbied for allocation of resources to the jail, resulting in the hiring of two additional staff for the jail's STD program.

There also can be valuable teaching opportunities on these planning groups. The Florida Department of Corrections' infection control coordinator is a member of the statewide Prevention Planning Group, where she believes her most important function has been to educate the other members about the correctional environment and the needs of inmate populations.

On the other hand, the absence of correctional representation on HIV Prevention Planning Groups, which is the case in most of the jurisdictions visited for this study, almost inevitably means that programs in correctional facilities receive insufficient attention and support. In turn, a critical impetus for collaborative programs will be missing.

Joint committees. *Service on other standing committees* provides opportunities to develop and enhance collaborations. In Illinois and New York, the public health and correctional departments are both represented on State interagency AIDS task forces, while in Missouri, Washington, and

New York, both departments serve on Governors' advisory councils on AIDS. New York's advisory council has a subcommittee on criminal justice that includes representatives of State corrections, health, and parole agencies. In Missouri, the health department's medical director serves on the department of correction's (DOC's) review committee for its health services contract.

The Florida DOC's medical director serves on the State TB Control Coalition and the department of health's (DOH's) medical director for HIV sits on the correctional department's medical ethics panel. A task force comprising staff from the jail, corrections center, and health department was convened in Memphis to address TB screening in jails. It has been proposed to keep this group in existence to provide a forum for discussion of other health issues in the jails and correctional center. In Rochester, a Jail Health Advisory Committee has brought together high-level managers at the jail and in the health department to address issues of common concern.

Regularly held meetings. In addition to serving together on standing committees, it is important for public health and correctional staff to conduct *regularly held meetings at both leadership and operational levels*. In Florida, there are quarterly coordination meetings of DOC and DOH staff on TB issues, as well as regularly scheduled collaborative TB case-review conferences. TB case-review meetings are also held in Missouri on a monthly basis. These meetings have identified errors, one involving a case in which treatment was wrongly terminated.

In contrast, a barrier to collaboration may have been the absence or infrequency of meetings at central office and facility levels. In one jurisdiction,

the lack of meetings between the heads and high-level management of relevant departments has led to a somewhat fragmented approach to the provision of public health interventions in the jails. The jurisdiction's approach has been characterized by overlapping functions, poor communication, and turf disputes.

Sharing information. Access to and exchange of information about individual patients is often critical to the success of collaborative efforts. This is particularly true when correctional or health department staff provide followup on test results or partner notification or continue patients on medications following their transfer or release. (Inmates may be transferred frequently from housing unit to housing unit within a facility as well as between different facilities. Inmates may also be released on short notice.)

In many of the visited jurisdictions, procedures have been developed to transfer medical records and provide interagency access to important clinical or locator information. In New York State, for example, health department staff have access to portions of the department of correctional services (DOCS) inmate information system so they can track transferred inmates within the system and ensure that HIV and PPD results and medication status are provided to the new facility. In Illinois, the health department was able to track and respond appropriately to a TB outbreak in the correctional system because their staff had access to the DOC database on inmate movements and transfers. The work of Missouri health department staff who conduct followup interviews in the prisons and elicit information about sexual partners is facilitated by access to the correctional department's HIV and

syphilis case logs and to inmates' automated medical records. Similarly, Chicago health department staff who conduct STD screening and treatment in Cook County jail depend on the jail's database for the locations and court dates of inmates and on the Chicago health department registry for their treatment histories.

Under a grant from the Corrections Program Office, U.S. Department of Justice, Florida's prison and jail leadership is developing a partnership in TB control with the primary objectives of coordination of services and exchange of information as inmates move from county jails to State prisons.

Correctional department access to health department databases can also be very useful. In Washington State, when the DOC wishes to determine the status of inmates being transferred or released, it can check health department databases on patients receiving medications for TB and patients receiving preventive therapy.

On the other hand, *problems with the availability and exchange of information* have impeded collaboration and undermined inmate health care. In many instances, vital medical records, including test results and medication status of transferred or released inmates, were never sent to the new health care provider or sent only after long delays. HIV antibody tests and PPD skin tests have had to be readministered because there was no record of previous testing. At one juvenile detention facility, the county health department was responsible for HIV counseling and testing but did not furnish test results to the facility's medical director. Inmates receiving combination antiretroviral therapy for HIV may arrive at a new facility without written

records of the specific regimen, and the new facility may be unable to obtain records from the previous facility within a reasonable period. Therefore, medications may need to be restarted.

Suggestions on how public health departments and correctional agencies can work together to expand and enhance health services for inmates are offered under "Policy Implications."

Conclusions

Collaborative efforts should be expanded to include organizations beyond public health and adult correctional agencies and to involve a broader range of criminal justice populations and organizations that offer needed services and linkages. Other types of organizations to include in comprehensive collaborations are probation and parole agencies, juvenile systems and facilities, community-based organizations, AIDS service organizations, substance abuse treatment programs, academic medical centers and universities, and other service providers.

Clearly, State and local government agencies and service providers in the affected communities bear the primary responsibility for development of collaborations. However, Federal agencies such as CDC and NIJ may be able to support expanded and enhanced collaborations in some ways. These include funding demonstration projects (such as CDC's enhanced STD screening and treatment efforts) and sponsoring conferences and forums that offer opportunities for staff of correctional and public health departments and other pertinent organizations to meet and discuss collaborations.

The development and distribution by appropriate government agencies of

T Policy Implications

This study identified many effective and promising public health/corrections collaborations to address problems of HIV/AIDS, STDs, and TB in correctional facilities, as well as gaps, shortfalls, and weaknesses in collaborative efforts. In general, the study found that inmate services and collaborations in the following areas could benefit from expansion and enhancement:

- Behavioral prevention programs.
- Inmate peer-based programs.
- Discharge planning and transitional services, including continuity of care, adherence to medication regimens, and social services to ease the transition to the community.

The study also found that most current collaborations involve public health departments providing or funding services in correctional facilities. This is, to be sure, an important aspect of collaboration that requires granting access to the facility as well as some interchange and discussion between public health and correctional agencies. But several actions are required to achieve comprehensive relationships:

- **Collecting and disseminating data by public health departments to demonstrate the disease burden in correctional and criminal justice populations.** Without these data, it may be very difficult to convince decisionmakers of the need for more resources and expanded collaborations.

- **Including correctional representatives on HIV Prevention Planning Groups.**

Such representation can help to ensure that correctional and criminal justice settings receive their fair share of attention and that their unmet resource needs receive appropriate priority.

- **Initiating or expanding funding by public health departments of services and staff in correctional facilities and other criminal justice settings.** Such funding support can be the first step in the development of full collaborations.

- **Recognizing the importance of interventions in correctional settings to the health of the larger community.** In particular, the importance of screening, early detection, and early treatment can be understood and reflected in program priorities.

Additional steps to consider

Additional, more specific steps may be taken to help ensure successful collaboration:

Improving the context for collaboration.

Use administrative, legislative, and regulatory powers to require collaborations:

- Include specific roles and requirements for health departments and correctional agencies for collaborative efforts in appropriate legislation and regulations.
- Formalize collaborative relationships between health departments and correctional agencies in memorandums of understanding or other written agreements.
- Establish and use the legal powers of health directors to require disease screening and other interventions as appropriate and ethical.

Building collaborative attitudes. Promote the following attitudes and philosophies that facilitate collaboration:

- Establish a commitment by health departments and correctional agencies to the principle that public health is part of public safety.
- Recognize that correctional facilities are part of the community. Additionally, virtually all inmates return to the community.

- Open correctional facilities to outside organizations that can provide valuable resources and expertise to address health issues.

- Build mutual respect for each others' missions, priorities, concerns, and capabilities. For example, address the legitimate concerns of correctional employees regarding occupational exposure to HIV, STDs, TB, and other diseases.

- Be willing to compromise and work within the reasonable rules and constraints of the correctional facility in order to achieve larger public health goals.

Operationalizing collaboration. Establish the following operational features to foster collaboration:

- Locate health department programs and staff in correctional facilities.
- Establish single, regularly accessible liaisons for collaboration at the central office and facility levels.
- Resolve logistical issues by, for example, providing trouble-free gate clearance for health department program staff and expediting callout and escorts for inmates attending health programs.

Improving communication. Improve communication and information exchange among all staff members in the following ways:

- Develop and implement better systems for accessing and exchanging important clinical and inmate-locator information at all jurisdictional levels.
- Establish joint health department/correctional committees at the leadership and operational levels.
- Hold regular joint staff meetings at the central office and facility levels.

guidelines for the prevention of HIV/AIDS and STDs in correctional settings might be helpful in fostering collaborations between public health and correctional agencies. Guidelines such as those developed by CDC for controlling TB in correctional facilities could provide a framework for discussion of the benefits of appropriate prevention, control, and treatment procedures.

In sum, correctional facilities are important points to access high-risk, underserved populations and offer opportunities to reach these populations with important health interventions. As the examples included in this report demonstrate, collaborative efforts can be successful in improving the health of inmates and benefiting overall public health as well.

Notes

1. Gilliard, D.K., and A.J. Beck, *Bulletin: Prison and Jail Inmates at Mid-year 1997*, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, January 1998, NCJ 167247.

2. Centers for Disease Control and Prevention, "HIV/AIDS Education and Prevention Programs for Adults in Prisons and Jails and Juveniles in Confinement Facilities—United

States, 1994," *Morbidity and Mortality Weekly Report* 45 (April 5, 1996): 268–271.

3. Maruschak, L., *HIV in Prisons and Jails 1995*, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, August 1997.

4. Centers for Disease and Control and Prevention, "HIV/AIDS Education and Prevention Programs."

5. Wilcock, K., T.M. Hammett, R. Widom, and J. Epstein. *Tuberculosis in Correctional Facilities 1994–1995*, Research in Brief, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, July 1996.

6. Glaser, J.B., and R.B. Greifinger, "Correctional Health Care: A Public Health Opportunity," *Annals of Internal Medicine* 118 (January 15, 1993): 139–145.

7. Hammett, T.M., J.L. Gaiter, and C. Crawford, "Reaching Seriously At-Risk Populations: Health Interventions in Criminal Justice Settings," *Health Education and Behavior* 25 (February 1998):99–120.

8. Hammett, T.M., and P. Harmon. *1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities*, Issues and Practices, Washington, D.C.: U.S.

Department of Justice, National Institute of Justice and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, forthcoming.

9. Dixon, P.S., T.P. Flanigan, B.A. DeBuono, J.J. Laurie, M.L. DeCiantis, J. Hoy, M. Stein, H.D. Scott, and C.C.J. Carpenter, "HIV Infection in Prisoners: Meeting the Health Care Challenge," *American Journal of Medicine* 95 (December 1993):629–35

10. Flanigan, T.P., K. Vigilante, J. Burzynski, G. Buble, J. Kim, S. Cu Uvin, L. Normandy, M. Snead, A. De Groot, M.L. De Ciantis, and B. De Buono, "Medical Care of HIV-Infected Prisoners: The Rhode Island Experience," *AIDS Clinical Research and Care: Meeting the Challenges of an Epidemic in Flux, Public Responsibility in Medicine and Research Conference Proceedings*, October 1992.

11. Flanigan, T.P., J.Y. Kim, S. Zierler, J. Rich, K. Vigilante, D. Bury-Raymond. "A Prison Release Program for HIV-Positive Women: Linking Them to Health Services and Community Follow-Up" (letter). *American Journal of Public Health* 86 (December 1996):887.

Appendix: Summary of Collaborati

Sites	Administration and Infrastructure						
	Health Department Responsibility	Disease Surveillance	Database Support	Inspections and Assessments	Quality Assurance	Staff Training	Linkage Development
Rhode Island		DOC medical staff report HIV, STDs, TB, and all other reportable infectious diseases to DOH.	DOH provides computer equipment. DOC provides database.	DOC medical director contacts DOH TB coordinator in cases of active/suspect TB in discharged population.	DOH reviews treatment of all cases.		DOC attends DOH HIV Advisory Committee. DOC is part of HIV Prevention Planning Group
New York		DOH collaborates on blinded HIV-seroprevalence studies and improved AIDS-case counting. DOH funded demonstration TB screening projects at DOCS intake facilities; 10 regional PHRs perform surveillance, case tracking, and contact investigations.	DOH access to DOCS database on inmate movements facilitates TB tracking and delivery of HIV-test results.	DOH assisted with investigation of MDR-TB outbreak in prisons. DOH assessed air handling in DOCS facilities and consults on specifications for negative-pressure rooms.	DOH and DOCS collaborates on HIV/AIDS case review. DOH monitors treatment of TB cases in DOCS facilities.	DOH provides TB training and technical assistance for staff of DOCS. DOH trains DOCS staff in HIV/AIDS transmission, prevention, workplace practices, and universal precautions.	Routine meetings are held between DOH and DOCS. DOCS participates in statewide meetings with contractors serving correctional facilities.
Washington		DOH collaborates on blinded HIV-seroprevalence studies. DOH documents STD morbidity in adult and juvenile facilities	DOH provides DOC staff with access to TB treatment and prevention therapy databases.	DOH surveyed HIV/AIDS, STD, and TB services in prisons. DOH inspects prisons each year and helps justify requests for resources.	DOH reviews treatment of active TB cases.	DOH reserves slots for DOC staff at annual STD clinical updates. DOH trains DOC staff on HIV counseling and testing.	
Florida		DOH-funded staff prepares TB case reports on inmates.		DOH-funded staff monitor TB treatment logs in prisons.	Collaborative TB case-review conferences are held regularly.	DOH holds annual health update conferences, including training in HIV counseling and testing. DOC and DOH jointly sponsor TB workshops.	Quarterly meetings are held with DOC and DOH staff.
Missouri		DOC provides HIV-screening reports to DOH. DOH conducts surveillance for HIV, STDs, and TB.			DOH teams monitor HIV and STD testing and treatment in State prisons. TB case-review meetings are held monthly. DOH participates in review of DOC health services contractor.	DOH provides training to probation and parole staff in HIV risk assessment and community linkages.	Governors Council on AIDS provides linkage among mar agencies, including DOC and DOH. Quarterly TB coordination meetings are held. DOC participates in HIV Prevention Planning Group.
Illinois		DOH collaborates with DOC on blinded HIV-seroprevalence studies.	DOH access to DOC database on inmate movements and locations facilitates TB tracking.		DOH reviews STD morbidity reports to assess treatment.	DOH trains DOC staff in TB and STD interviewing and counseling techniques.	
Houston (Harris County), Texas				DOH surveyed HIV/AIDS, STD, and TB services in jails.		DOH assists in providing and coordinating STD training to jail clinicians.	
Memphis (Shelby County), Tennessee	DOH is responsible for health services in jails.						
Rochester (Monroe County), New York						DOH trains clinicians at jail and juvenile detention center.	DOH funds women's jail committee. DOH serves with jail staff on Jail Health Advisory Committee.
San Francisco, California	DOH is responsible for health and mental health services in jails.	DOH provides HIV/AIDS, STD, and TB surveillance and disease tracking.				DOH TB control staff trained jail staff in placing and reading PPDs.	DOH launched and coordinated Bay-area TB control group, bringing together public health and correction staff.
Chicago (Cook County), Illinois	Cermak Health Services, a unit of county government, provides all jail health services.	DOH provides onsite STD surveillance.	DOH staff have access to jail computer and provide access to city syphilis registry		DOH ensures appropriate STD treatment and participates in infectious disease quality-assurance meetings	DOH provides TB training at correctional officer's academy and STD training to jail clinicians.	

DOH = Department of Health

DOC = Department of Correction

DOCS = Department of Correctional Services

MDR = Multidrug Resistant

Efforts Identified During Site Visits

Policy Development		Service Delivery					
Legislation and Policy	Clinical Protocols	Education/Prevention Programs	Testing, Screening, and Followup	Treatment	Discharge Planning and Transitional Services	Laboratory Services	
DOH and DOC collaborated on DOC's HIV/AIDS policy. DOH and DOC jointly drafted legislation on HIV testing in response to incidents and disclosure of HIV status.	DOH and DOCS jointly develop HIV/AIDS treatment protocols and TB control policy.	DOH (with CDC funding) funds prison prevention staff, who offer HIV orientation and multisession programs and coordinate inmate peer program.	DOH funds HIV pretest and posttest counseling and partner notification in prisons. DOH provides TB outreach and followup for persons released from jail and prison.	DOH and DOC jointly fund treatment, which helps ensure continuity of care. Academic medical center involved.	DOH and DOC jointly fund discharge planning and community linkage. DOC medical director contacts DOH TB coordinator in cases of active/suspect TB in discharged population.	State lab performs confirmatory HIV testing	
		\$3 million per year for HIV/AIDS services were provided to prisons, juvenile facilities, and parolees for peer-led programs. DOCS funds regional teams from AIDS Institute to present HIV educational programs.	AIDS Institute regional teams and funded contractors provide HIV counseling and testing. DOH (with CDC funding) supports STAT syphilis screening and treatment programs in selected county jails. DOH and DOCS developed and implemented mandatory TB screening for inmates and staff.	DOH funded a demonstration of directly observed preventive therapy for TB at DOCS intake facilities. DOH reps perform TB case management at DOCS facilities.	AIDS Institute supports Prisoners Hotline and transitional services for inmates with HIV/AIDS. DOH's TB bureau promotes collaborative planning between DOCS and Parole Department, links releasees and community providers, and monitors treatment in community.	DOH lab processes HIV and STD tests for DOCS inmates.	
DOH helped draft and review DOC infection control manual. DOH reviews other policies. DOH helped draft legislation on disclosure of HIV status.		DOH distributes STD prevention literature to State prisons. DOH funds a CBO to provide HIV prevention work in prisons.	DOH provides HIV/STD partner notification services in prisons. DOH provides special STD screening in two county juvenile detention centers. DOH offers chlamydia screening at women's prison.			DOH provides some HIV and STD testing for State prisons.	
DOC coordinates all HIV/AIDS, STD, and TB policy guidelines with DOH.	Governors Council on AIDS reviews HIV/AIDS treatment protocols for inmates.	DOH funds peer-based HIV/AIDS prevention program at Lawtey Correctional Facility. Program is being expanded to other facilities.	State/county DOHs provide STD screening, followup, and partner notification in many State prisons, county jails, and juvenile facilities. DOH-funded staff do TB followup.	County DOH follows up on TB treatment of released inmates.	DOC coordinates with DOH on discharge planning and continuing care for inmates with HIV/AIDS and TB.	DOH provides STD testing for many county jails.	
DOH and DOC collaborated on point-scoring assessment of TB isolation, developed guidelines for TB screening and treatment, and compromised on condom distribution at release.		DOH provides training for inmate HIV/AIDS peer educators in two DOC facilities.	DOH funds HIV/STD/TB screening and partner notification services in prisons. Three regional DOH teams conduct followup interviews with syphilis-positive inmates. DOH assists with TB screening and followup in prisons. DOH funds peer-based HIV prerelease programs.	Joint project with DOC/Parole Department provides incentives to refill TB prevention medication prescriptions.			
		DOH funds HIV/AIDS education programs at prerelease centers. DOH funds and provides training for peer HIV/AIDS prevention program in most facilities. DOH trained 100 peers, and peers made 17,000 contacts with inmates in 1996.	DOH staff conducts STD contact investigations.			State public health lab provides all STD testing for State prisons.	
		CDC funds VCRs and TVs to show HIV prevention videos in city jail.	County DOH offers HIV counseling and testing. City DOH provides inmate followup for HIV/AIDS and STD treatment, and referral. City DOH provides partner notification to outside contacts. City DOH/jail team provides limited syphilis and HIV testing in several facilities. City DOH performs contact investigation on all active TB cases in jail.	City DOH/jail team provides some medications for STD treatment in jail. County provides directly observed therapy for jail releasees with TB.			
Health officer mandated universal PPD screening in jails.		DOH/jail team offers HIV/STD educational services at county jails.	DOH/jail teams provide HIV counseling, testing and partner notification in jails. DOH/jail teams provide STD screening, followup interviews, partner notification, and evaluation of PPD-positive TB tests.				
	DOH provides jail inmates with education in TB preventive therapy.	DOH teams provide HIV counseling and testing, and STD testing and followup in jail and juvenile facilities. DOH TB staff follow up on PPD positives in jail and community.			DOH hired discharge planner to work in jail.		
DOH and sheriff's department compromised on HIV testing and disclosure policy.		DOH's Forensic AIDS Project (FAP) offers HIV education and prevention programs and distributes condoms in jails.	FAP provides HIV counseling and testing. DOH screens for STDs in jail, follows up in the community, and performs TB screening and followup.	FAP provides medical and psychological services for inmates with HIV/AIDS.	FAP provides discharge planning and community linkages for inmates with HIV. Jail staff and DOH TB control staff coordinate discharge planning and followup of patients with active TB.		
DOH and DOC medical director collaborated to initiate universal pregnancy screening at jail intake.		Chicago DOH provides \$340,000 per year for HIV prevention programs, which funded 7 of 10 HIV educators in county jail.	DOH funds STD screening staff at jail (with CDC funding). DOH provides STAT (immediate) syphilis screening and treatment for women in jail. DOH follows up in community and provides PPD results.	DOH provides directly observed therapy to jail releasees with TB.		State DOH lab provides confirmatory syphilis testing.	

CBO = Community-Based Organization

Theodore M. Hammett, Ph.D., a Vice President at Abt Associates Inc., was the principal investigator for this study. The project was supported by contract OJP-94-C-007 awarded to Abt Associates Inc. by the National Institute of Justice.

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Findings and conclusions of the research reported here are those of the author and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

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Cooperative Extension

Evaluating Collaboratives

Reaching the Potential

July 1998

Program Development and Evaluation
University of Wisconsin-Extension
Cooperative Extension
Madison, Wisconsin

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Jean Geran

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Extension

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PREFACE

Work that resulted in this manual began in 1995 when family living agents of the University of Wisconsin-Cooperative Extension began asking questions about how to evaluate the work of coalitions and collaboratives. They found themselves increasingly involved in these partnerships and saw them as a new type of programming. Their traditional way of evaluating did not seem appropriate. A work group was established to explore the issue and delve into the literature. Over the first year, we held a series of workshops and gained insight from interactions with Extension faculty and other practitioners working with community groups of all types. We were excited by the amount of literature we found, principally in the field of family development and substance abuse prevention, and by the evolving thinking in the field of evaluation relevant to the developmental nature of collaboratives.

This manual grew out of those ideas and discussions. It is a 'work in progress', since each day our appreciation and understanding of collaboratives increases. We believe in the purpose and philosophy of collaboratives and systems thinking. Our approach to evaluation is based on the value of learning to improve understanding and performance. We do not want collaboratives to become another 'bandwagon' approach that misses its potential because of unrealistic expectations and inadequate support.

Readers looking for a 'cookbook' or 'best method' for evaluating collaboratives will be disappointed. Our purpose is to provide a compendium of ideas and research for you to think about and choose from as you help your collaborative reach its potential.

Use of the Manual

As you work with the manual, we would appreciate your feedback and comments. Please direct these comments to Ellen Taylor-Powell, Rm 609 Extension Building, 432 N. Lake St., Madison, WI 53711. Phone: 608-262-2169. FAX: 608-262-9166

Creating Partnerships

This section is designed to be read in conjunction with other material on this site - listed below - which deals with collaboration between different interests involved in urban and rural regeneration programme (renewal or revitalisation are terms also used).

The term 'partnership' is now widely used where more than one organisation or interest is involved in, for example, an urban or rural regeneration programme. It may be too widely applied to situations where one powerful organisation is doing no more than consult with others, or mask fundamental differences of approach and objectives that will later lead to conflict.

Building Effective Local Partnerships (Local Government Management Board) offers as a definition:

A partnership is an agreement between two or more partners to work together to achieve common aims.

If you want to use any of the material, please contact me. David Wilcox <david@partnerships.org.uk>

Introduction to Partnerships

This Introduction - below - deals with:

- The characteristics of successful and failed partnerships.
- Making neighbourhood renewal work
- The difference between participation and partnership
- Some apparently easy answers to partnership
- Guidelines for creating partnerships
- Strategies for partnership and participation

Some of the topics are covered in more detail in other material on this

site.

- [The Guide to Development Trusts and Partnerships.](#)
 - **New - A Guide to Partnerships** (rtf document) [download here.](#)
 - [An A-Z of Partnerships](#) (latest version [here](#) -200K)
 - [Information sheets](#) on creating community development trusts
 - [The Guide to Effective Participation](#) which deals with some of the wider issues of community involvement.
 - [Other Internet resources](#)
-

Successful partnership

The following factors for success emerge from surveys of partnerships, and workshops of practitioners involved in creating and running partnerships:

- Agreement that a partnership is necessary.
- Respect and trust between different interests.
- The leadership of a respected individual or individuals.
- Commitment of key interests developed through a clear and open process.
- The development of a shared vision of what might be achieved.
- Time to build the partnership.
- Shared mandates or agendas.
- The development of compatible ways of working, and flexibility.
- Good communication, perhaps aided by a facilitator.
- Collaborative decision-making, with a commitment to achieving consensus.
- Effective organisational management.

Failed partnership

The following are characteristics of failed attempts at partnership, or warnings that something is going wrong:

- A history of conflict among key interests.
- One partner manipulates or dominates.

- Lack of clear purpose.
- Unrealistic goals.
- Differences of philosophy and ways of working.
- Lack of communication.
- Unequal and unacceptable balance of power and control.
- Key interests missing from the partnership.
- Hidden agendas.
- Financial and time commitments outweigh the potential benefits.

Drawn from workshops and sources [here](#)

Top of page

Making neighbourhood renewal work – in theory

A report by Marilyn Taylor, published by the Joseph Rowntree Foundation in March 2000, argues that effective Neighbourhood Management in the future will depend on the following principles:

- Joined up strategy and action must be driven through all levels of public policy-making and provision - from top to bottom, from back room to front line –with transparency and multi-layered accountability as the guiding principles.
- Joined up working will require fundamental changes to the cultures and career structures of both government and the public service professions.
- A strong infrastructure is required in order to spread rather than protect knowledge, resources, skills and learning.
- There is no change without risk - frameworks for performance measurement, regulation and audit must be broad enough to allow local autonomy.
- There will be no sustainable change unless communities themselves are given the power and responsibility to take action.
- As well as engaging communities in decision-making, Neighbourhood Management must open up quality public service employment opportunities to members of local communities and transfer assets into community ownership.
- A long-term perspective is essential if integrated approaches to social inclusion are to be sustainable: enough time must be allowed

to develop capacity and commitment in both communities and local public authorities.

- A strong and unequivocal message from central government is required if past barriers to change are to be overcome.

A summary of the report is at

<http://www.jrf.org.uk/knowledge/findings/foundations/pdf/310.pdf>

But is it working in practice?

Another Joseph Roundation Foundation report, by a team at Goldsmith's College, explored the experiences of residents involved in urban regeneration projects and found all far from well on the ground. They concluded:

'Communities are diverse and local interests may conflict with each other. If the community is seen as homogenous then only the most powerful voices will tend to be heard.

'Residents felt there was a gap between the rhetoric that demands community participation in area regeneration programmes and the realities of work on the ground.

'The study did find examples of good practice, but residents also had major criticisms to make. Too often, in their view, the mechanisms for effective community involvement had been inadequate, with too little time for effective consultation. Many commented that there had been insufficient support and not enough training (a conclusion shared by many professionals).'

Summary available at

<http://www.jrf.org.uk/knowledge/findings/housing/pdf/770.pdf>

Participation consultant Drew Mackie reaches similar conclusions in an article 'Dancing while standing still'

<http://www.partnerships.org.uk/articles/still.htm>

He says: 'Two problems have emerged:

'Communities are under increasing pressure to become involved. This can put a strain on the time of community activists and the community itself. "I participated last week!" is becoming a frequent refrain as communities are consulted on matters of health, transport, housing, education,

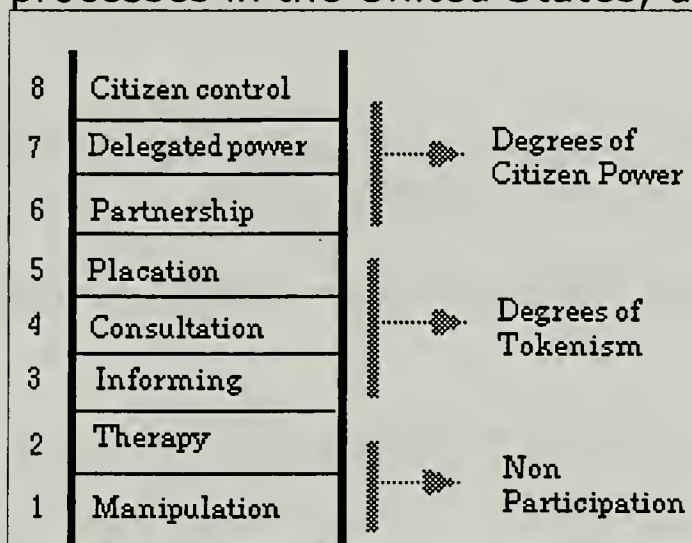
planning, economic development, etc. The quality of such consultation is necessarily variable and many bodies are consulting because they have to, not because they believe in it.

'Consultation itself does not guarantee delivery. A proper community involvement programme will involve the delivery agencies so that false expectations are not raised and delivery becomes part of the process. Communities are increasingly complaining that their involvement has not resulted in better delivery. "Why should I bother when nothing happens?"'

Participation and partnership

It may be easier to develop an appropriate approach to partnership if you have a simple theoretical framework for thinking about the wider issues of participation. These ideas are developed in detail in the Guide to Effective Participation.

Sherry Arnstein, writing in 1969 about citizen involvement in planning processes in the United States, described a ladder of participation.



1 Manipulation and 2 Therapy. Both are non participative. The aim is to cure or educate the participants. The proposed plan is best and the job of participation is to achieve public support by public relations.

3 Informing. A most important first step to legitimate participation. But too frequently the emphasis is on a one way flow of information. No channel for feedback.

4 Consultation. Again a legitimate step attitude surveys, neighbourhood meetings and public enquiries. But Arnstein still feels this is just a window

dressing ritual.

5 Placation. For example, co-option of hand-picked 'worthies' onto committees. It allows citizens to advise or plan ad infinitum but retains for power holders the right to judge the legitimacy or feasibility of the advice.

6 Partnership. Power is in fact redistributed through negotiation between citizens and power holders. Planning and decision-making responsibilities are shared e.g. through joint committees.

7 Delegated power. Citizens holding a clear majority of seats on committees with delegated powers to make decisions. Public now has the power to assure accountability of the programme to them.

8 Citizen Control. Have-nots handle the entire job of planning, policy making and managing a programme e.g. neighbourhood corporation with no intermediaries between it and the source of funds.

Arnstein's ladder of participation suggests some levels are better than others. I think it is more of a case of horses for courses different levels are appropriate in different circumstances.

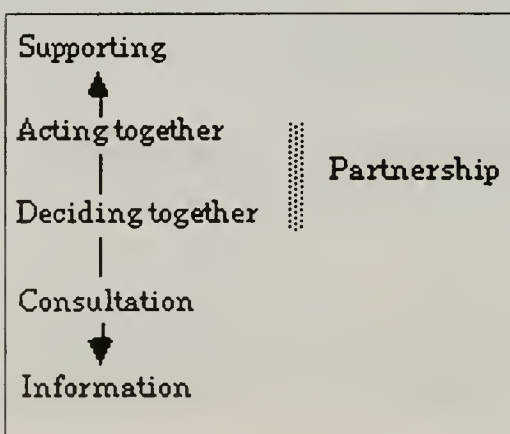
Five stances

The key issue is what 'stance' you take if you are an organisation initiating or managing a process of participation or partnership building.

I suggest thinking of five levels or stances which offer increasing degrees of control to the others involved.

Information: The least you can do is tell people what is planned.

Consultation: You identify the problems, offer a number of options, and listen to the feedback you get.



Deciding together: You encourage others to provide some additional ideas and options, and join in deciding the best way forward.

Acting together: Not only do different interests decide together what is best, but they form a partnership to carry it out.

Supporting independent community initiatives: You help others do what they want perhaps within a framework of grants, advice and support provided by the resource holder.

The 'lower' levels of participation keep control with the initiator but they lead to less commitment from others. Partnership operates at the levels of Deciding Together and Acting Together.

Information is essential for all participation but is not participatory in itself.

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Apparently easy answers to partnership

When local authorities, private sector bodies, and indeed voluntary organisations, are faced with tight timetables and firm guidelines it is difficult to think through the complexities for participation and partnership. There is a strong temptation to go for a quick fix and hope to sort things out later. Here are a few health warnings on different forms of partnership.

Set up a forum

A forum may seem an easy way to get a wide range of interests together and act as a sounding board, but should it be labelled a partnership? For example:

- Will the different interests be able to develop a common vision or will they simply argue for their individual priorities?
- How representative will the forum be? Will it just represent large, well-organised groups?
- Will the implementing organisations be bound by forum decisions?

Create special interest fora

Rather than putting all interests together, give them each a forum. But then:

- Are they a self-selecting group?
- Who decides the issue or area to be covered?
- How will an overall vision be developed?
- Will it be possible to support and service all the fora: what resources are available?
- Will there be sufficient interested people with time to spare?

Appoint community representatives

Instead of creating more organisations, give community representatives seats on the decision-making bodies. However:

- Who will choose the representatives and on what basis?
- Will they have the same support and access to information as others on the committee?
- How will they discover and express the views of community interests?
- What checks will people have on their representatives?

Set up a Community Development Trust

Development trusts are non-profit-distributing companies, which may seek charitable status. They have their own staff and are governed by a Board including a range of interests. They are described in more detail elsewhere in the information sheets but they may not always be the most appropriate form of partnership.

Consider:

- Do you have the time and expertise to create and run a company?
- Will funding be available to pay staff in early years?
- Will there be ways in which the trust can earn income to maintain operations in the longer term?

Form a steering group of all interests

A steering group would have more say than a forum, but not control resources like a Development Trust. It may seem a reasonable compromise, but consider:

- Will the members expect more power than implementing bodies are prepared to give?
- Will the different interests have sufficiently similar styles of working to operate together?
- How will steering group members be selected, and how will they relate to their 'constituents'?
- Will they be able to deliver, or will they just be another talking shop?

Run a Planning for Real exercise

Instead of relying solely on formal structures, using workshop techniques allows participation to be taken to residents and others. Planning for Real is one powerful technique which allows participants to build models of the neighbourhoods they want, and develop action plans. It provides more active involvement than public meetings or fora. However:

- Does running the exercise imply that the results will be adopted? Are budgets sufficiently flexible for this?
- Will a development worker be available to support groups which form around the ideas developed?
- Will there be time for ideas to be worked through?
- Who will implement?

Get the money first, worry about partnership later

Dress up funding bids with token representation, then bring people on board when the money is there. This may be convenient for the bidding body however:

- Will it then be possible to gain the commitment of other partners whose support, skills and funds may be needed?
- Will local groups challenge rather than support plans which have been developed without them?
- Will the funder see through the ploy?
- Will plans be flexible enough to respond to local needs and demands?

Guidelines for partnership

Here are some guidelines which may offer you a way of deciding what sort of partnership you may wish to create, and how to make a start.

1. Clarify your own aims and objectives in forming a partnership. What are you trying to achieve, and how will you explain that?
2. Identify the stakeholders the key interests who can help or hinder the project or programme and put yourself in their shoes. Who holds the power?
3. Consider who you really need as partners, and who would really want to be a partner. Some stakeholders may simply want to be consulted.
4. Before approaching potential partners, make sure you have support and agreement within your own organisation about working with others.
5. Make informal contact with partners to find out about their attitudes and interests before putting formal proposals.
6. Communicate with your partners in language they will understand, focusing on what they may want to achieve.
7. Plan the partnership process over time. For example, a new organisation may well take a year to set up.
8. Use a range of methods to involve people workshop sessions as well as formal meetings. Be sociable.
9. Encourage ideas from your partners. Ownership leads to commitment.
10. Be open and honest.

Strategies for Partnerships and Participation

These guidelines were developed in 1999 by the Joseph Rowntree Foundation at the request of the UK Government's Department for Transport and the Regions. They provide guidance for Single Regeneration Budget bids:

Getting started

- Map local organisations;
- Understand local priorities and skills;
- Build confidence through early project work;
- Develop a vision and action plans with local communities.

Involving communities in partnerships

- Create partnership structures that work for local communities;
- Make resources available for community groups;
- Arrange training for both community activists and professionals;
- Help community groups with administrative and financial procedures.

Creating strong local organisations with their own assets

- Develop a partnership 'forward strategy', including a strong role for community groups;
- Consider possible models for successor organisations including: development trusts; neighbourhood management organisations; LETS; and credit unions.

Developing an infrastructure to build and sustain community organisations

- Accept that community organisations need long-term support;
- Contribute to the better co-ordination of training and support services;
- Take steps to secure pre-bid resources for community groups.

Monitoring progress

- Establish a framework for evaluating both concrete outputs and key processes in community involvement;

- Ensure appropriate monitoring of progress both by the partnership and by Government Offices for the Regions (Regional Development Agencies after April 1999).

Report at:

<http://www.jrf.org.uk/knowledge/findings/foundations/pdf/F169.pdf>

[Back to Partnerships at Partnerships Online](#)

Prepared by David Wilcox david@partnerships.org.uk October 23
2000

<http://www.partnerships.org.uk/AZP/part.html>

An A to Z of partnerships and networks

This is a revised version of an A-Z originally developed in 1994. See also the Guide to Effective Participation which also includes an A-Z with a focus on community involvement. If you want to use any of the material, please contact me. David Wilcox <david@partnerships.org.uk>

Accountability

The lowest level of Government is the individual.

Accountability means knowing who is answerable to whom - often difficult in a partnership or network where paid staff have different employers, and activists a range of allegiances. To clarify accountability in practice consider:

- Who can stop someone doing something?
- Whose permission is needed for someone to act?
- Who pays them?

Think of accountability through a process of community involvement as well as representation, and in relation to specific projects as much as structures. See Terms of reference.

Action plans

Ideas won't keep, something must be done about them. Alfred North Whitehead.

Action plans answer questions of: what do we do next? who does it? with what resources? Action minutes after meetings should ensure something happens, and clarify accountability.

Activists

Activists is used here to mean those people active in local organisations and/or developing projects for community benefit, but who are not paid workers. While clearly key people to involve in partnerships and networks, there is a danger of the same faces dominating and being seen as a clique. To avoid this, and involve more people, do some networking and run workshops.

Agendas

It might be termed the Law of Triviality. Briefly stated, it means that the time spent on any item of the agenda will be in inverse proportion to the sum involved. C. Northcote Parkinson.

Agendas are the traditional means of planning a formal meeting, circulated with back-up papers. Workshops need a different approach, with charts, posts-its and other ways of stimulating interaction. See also Outcomes, Team building, Vision.

Agendas - hidden

The different interests in a partnership or network will have different aims, and agendas for achieving them. Success comes from finding where these agendas overlap. Conflict develops from lack of understanding or disclosure. The question is: 'What are we trying to achieve - together?' Finding the answer usually requires a process to develop trust, projects with priorities — and recognising that communities are not uniform but include many different interests

Aims and objectives

Aims are a written description of what a group or organisation is trying to achieve, and the objectives are the methods by which they may do that. The different interests in a partnership will all have their own aims and objectives — so focus on where these overlap. See also, Outcomes, Purpose, Vision.

Allies

You will need some in forming a partnership — to provide personal support and act as a sounding board; offer advice; host meetings; champion your ideas.

Asset base

If partnerships are to sustain their activities beyond a few years, they need to plan how to generate revenue after initial grants ends. Development Trusts general aim to create an asset base of land or buildings which may provide rental or other income.

Attitudes

Some of the main barriers to participation and partnership lie in the attitudes people bring to the process. Residents may lack confidence or feel action is not their responsibility. Officials may see getting the job done quickly as a top priority, even if it doesn't meet the needs of all concerned. Councillors may feel their power

is eroded by sharing decision making with local people. Non-elected representatives may be uncertain of their roles. Help people to get to know each other and broaden their ideas through workshops, and socials.

See also Commitment, Ownership, Stakeholders.

Barriers to partnership

These may include

- One partner manipulates or dominates.
- Differences of philosophy and ways of working.
- Lack of communication.
- Unequal and unacceptable balance of power and control.
- Unclear, hidden or incompatible agendas.
- Some partners brought in late.

Address these through a process to build trust. See also Agendas, Control, Communication, Partnership building.

Beneficiaries

Partnerships are generally formed with the expressed intention of providing some wider benefit... but there is always a danger that they become inward looking. Who are the intended beneficiaries? Do they get a say through community involvement or representation?

Benefits

The benefits of forming a partnership for the partners may include bidding for funds otherwise not available; pooling skills and experience; getting a new angle on a problem. Does this outweigh costs — and does it also benefit the intended beneficiaries?

Bids for funding

Funding bids are probably the main trigger for partnership formation. In preparing bids:

- Treat the bid as the start of business planning, if you are forming a new organisation.

- Aim for a mix of funding — not just one source.
- Think through aims and objectives independently of the bid. Meet your own purpose as well as your funder's.
- Place the bid in a partnership-building process.

Brainstorming

Think sideways! Edward de Bono.

Brainstorming is defined as 'a means of getting a large number of ideas from a group of people in a short time'. It is one of the most widely used workshop techniques, and useful when partnerships are trying to shape their agenda and tackle problems creatively.

Brainstorming

After you have defined the problem or question:

- Throw up every idea you can. Don't discuss or reject any.
- Record ideas on a chart — one idea may spark off another.
- When ideas dry up, cross off those agreed as ludicrous.
- Look for common themes and possible solutions.
- Draw up an action plan.

Business planning

Any partnership which aims to keep going in the long term needs a business or development plan. For a non-profit organisation the plan will balance the costs and income of three parts of its operation:

- The projects, products or services provided by the organisation.
- The core staff, premises and equipment.
- Any fundraising.

The business plan should cover at least three years and show how fundraising and any income earned from projects covers the core costs.

See also Companies, Constitution, Fundraising.

Champions

Partnerships work because of people. You will need to find people prepared to champion the idea within potential partner organisations and in the wider community. Value these allies, and bring them together in socials as well as more formal events.

Change

Partnerships usually involve change: seeing things from other people's point of view, respecting into other people's ways of doing things and changing your own. This can be threatening, but it can also be enormously creative. It can be painful, but it can also be fun. Either way it takes time, which is why creating partnerships should be seen as process, not a structural fix.

Charitable status

A charity is not a particular form of organisation, different from a company or community group. Both may be charities, if they are accepted and registered as such by the Charity Commissioners. (In Scotland and Northern Ireland registration is directly with the Inland Revenue). To be registered as a charity an organisation must have appropriate objects.

Charitable status adds credibility to an organisation, provides some tax benefits, and enables it to apply to large charities for funding. In general charities can only make gifts to other charities. There are, however, restrictions on trading and members of any management committee have substantial additional responsibilities as trustees. Consulting a solicitor or organisation specialising in charity law will save you a lot of time and possible confusion.

Charts

These may be flip charts — pads of large paper used with an easel — or simply lining paper tacked to the wall. They are an essential tool of partnership-building, because they help you break out of committee mode. Committees need agendas and minutes — workshops need charts. In using charts:

- Stick charts up as you write them, so people can see early work.

- Offer the pen to others in the group.
- Keep charts or photograph them as a record.

Cliques

Two complaints are often heard in community-based organisations: those on the outside maintain a small clique of people decides everything, and no-one else can get a look in. Those on the inside complain they are overworked and others are apathetic. To avoid this, if you are inside aim for transparency, and practice community involvement. Think about other people's agendas as well as your own. If you are outside, look for some positive ways to engage... go for practical collaborations.

Commitment

The centre line of partnership-building is gaining commitment. It depends on developing a shared vision, and some ownership of the ideas which are to be put into practice.

Committees

What is a committee? A group of the unwilling, picked from the unfit, to do the unnecessary.
Richard Harkness.

Committees of partnership organisations can pose particular problems because almost inevitably people come from different background, and probably haven't worked together before. In order to overcome this, run workshops and organise socials to complement formal events

Meetings checklist

To improve your committee meetings, get members to agree to:

- Read papers beforehand and bring them to the meeting.
- Check what they don't understand and research background.
- Turn up at the right time and stick to the agenda.
- Think before speaking and listen to other people .
- Seek decisions on which all can agree.
- Record what needs to be done.

- Read the action minutes and take any action necessary.

Communication

Information is giving out; communication is getting through. Sydney J. Harris

Effective communication involves considering how your message will be received as well as how you send it: the meaning of any communication lies in the response you get. Obvious barriers are:

- Lack of clarity about what you want to get across.
- Jargon.
- Hostility to you or your organisation.
- Lack of credibility in the message or the person giving it.

Community

Do not do unto others as you would that they should do unto you. Their tastes may not be the same. George Bernard Shaw

Community is a term so widely applied that it is in danger of losing any meaning, like 'members of the public'. Aren't we all? It is more useful to think of a large number of over-lapping communities distinguished by the characteristics of their members, and the common interests which tie members together and give these characteristics a shared significance. Because individuals may belong to many different communities at the same time, different allegiances may people pull in different directions. There are likely to be competing and conflicting interests within communities. See also networks.

See also Stakeholders.

Community forum

A community or neighbourhood forum is a regular meeting of community activists and interest groups which may also involve local business, political, religious and social organisations. It may be useful for discussion of issues of concern to local interests, and for stimulating contacts and networking. A forum is not so good for turning discussion into action, where some complementary 'do it' organisation like a Development Trust may be needed.

Setting up a community forum

- Avoid domination by any one interest group.

- Consider splitting meetings into small groups so people have more chance to contribute.
- Seek an independent widely-respected chair.
- Make any servicing of the forum - developing agendas, recording discussion - as independent as possible.
- Don't make the forum the only channel for communication.

See also Networking, Small groups, Structures.

Community Involvement

Partnership bodies can be just as inward looking and autocratic as larger bureaucracies. In planning community involvement:

- Think beyond 'the community' to different interests.
- Consider the level of participation which may be appropriate. Be explicit about how much 'say' and involvement people may have.
- Meet people informally.
- Use a range of participation methods — print, events, workshops — if you are aiming for more than basic information giving.

Involve partners, and treat them as communities in their own right, and run internal workshops to gain commitment.

Companies

A particular form of company, the company limited by guarantee, is increasingly popular as an organisational structure for partnerships. Companies limited by guarantee do not have shareholders — instead their members agree to pay a nominal sum, often only £1, if the company fails. The rights of these members to appoint members of the governing body — the Board — are defined by the constitution — the Memorandum and Articles of Association. The company does not distribute surpluses as profits, but reinvests them in the company. If the members of the Board are unpaid, and the company has appropriate objects, it can seek charitable status.

See also Development Trusts and structures

Constitution

A constitution sets out governing rules for an organisation. For a company it is the Memorandum and Articles of Association. Constitutions are important at the beginning, when a body is being set up, and when there is an argument about control. Generally:

- Clarify aims and objectives, vision, and an action plan before drafting the constitution.
- Avoid using the constitution to resolve disputes.
- Consult a solicitor with experience of non-profit organisations if you are forming a company.

Constitutions should come after you have decided what the partnership is going to do. In the meantime, you may need some interim arrangement to guide the start up process, like a steering committee.

Consultants

A consultant is someone who borrows your watch to tell you the time, and charges you by the minute to do it.

Consultants may be most helpful for partnerships if:

- They act as 'process consultants' to help groups through the partnership-building process, and/or
- They act as independent facilitators during that process
- They have clear briefs for specific project studies.
- They provide support and training around key issues.

It is a mistake to ask consultants to design partnership structures or programmes unless they work closely with all the key interests.

Consultation

Consultation is the level of participation at which people are offered some choices on what is to happen, but are not involved in developing additional options. As such it is not a level of partnership.

Control

Control in partnerships tends to lie with those who have the money, skills and administration — however well intentioned they

may be in seeking to involve others. For that reason partnerships formed around existing organisations may seem very unequal to other participants. Ways around this include:

- Checking whether 'partnership' is the right label for what is being attempted. Would consultation or contract be more appropriate?
- Being explicit about accountability and terms of reference.
- Setting up formal partnerships when the aim is to share control.
- Dispersing control by creating a network structure around projects.

See Networks, Power, Structures

Costs

Partnerships do cost time, money and commitment if they are to work. Creating the partnership can take up to a year in the case of a formal structure like a development trust. They will need volunteer or staff time, and resources for projects. Will the costs outweigh the benefits?

Definition

It is difficult to provide a single definition for partnerships, which can vary considerably in structure and purpose. However, they generally bring together interests from different sectors towards a common aim; share risks, skills and resources; and seek to achieve mutual benefit and synergy. Partnership is more than loose cooperation, coordinating separate activities - or contracting for services.

Democracy

Incorporated partnerships like Development Trusts which aim to regenerate neighbourhoods may face challenges over their accountability to local people, and calls that their governing bodies - the Board - should be democratically elected.

Some trusts do hold elections, either within the community as a whole, or among local organisations. However, there may be tension between this desire for representation and the need to appoint Board members who have the confidence and competence to run a company, and possibly also act as trustees. It is possible to have a mix of appointed and elected Board members. Plan

effective community involvement to ensure some participative democracy.

Development trusts

The Development Trusts Association defines Development Trusts as:

"Community-based organisations working for the sustainable regeneration of their area through a mixture of economic, environmental and social initiatives. They are independent, not-for-profit bodies - often registered charities - which are committed to the involvement of local people in the process of regeneration and aim to be locally accountable in the work they do."

They should not be confused with community trusts, which are fundraising and grant-making bodies. Development Trusts are usually incorporated as a non-profit distributing company with several paid staff to work on projects. They often aim to develop an asset base to ensure their sustainability.

Director

The term director may have two meanings in a Development Trust: first, a member of the Board who is a director under company law, and probably unpaid; second, the chief member of staff, perhaps termed the executive director. He or she will probably not be a member of the Board, and certainly cannot be if the Trust is a charity.

Electronic forums

Email or World Wide Web makes it simple (for those online) to engage in collaborative working or discussions without having to be in the same place, or on the phone, at the same time. Forums can be another tool of community involvement — but are no substitute for 'real' meetings.

Email

Email transforms partnerships in two ways: first it enormously increases efficiency of operation through easy one-to-one messaging, and many-to-many electronic forums. Second, it challenges hierarchies and makes it easier to operate through equal-status teams. Since anyone can communicate with anyone else anytime, decisions don't have to wait on committee meetings.

Events

Partnerships are built as much through the relationships of people as formal structures; and the way to build relationships is by bringing people together. Events are the milestones in the process of creating a partnership; whether formal events like steering group and Board meetings, presentations or launches, or informal events like breakfast briefings, lunches or socials.

Face-to-face

As opposed to face-to-screen.... F2f is used particularly by online people to remind themselves that sometimes the best way to communicate is to put one head in front of another, preferably in a convivial environment.

Facilitation

Facilitators are to workshops what chairpersons are to committees. They use charts, post-its and other techniques like brainstorming and SWOT to help groups establish priorities and develop action plans — rather than work through a formal agenda. You need both in partnerships.

Factors for success

These include:

- An agreed need that a partnership is necessary
- An agreed strategy with clear objectives
- Respect and trust between different interests.
- Compatible ways of working, and flexibility.
- Being effective at managing and delivering.
- Time to build the partnership.

Five Ws plus H

The simplest questions are the hardest to answer. Northrop Frye

A simple checklist to help you think of issues:

What are you trying to do, decide, explain?

When must you start and finish?

Why is it necessary?

Who needs to be consulted, involved?

Where is it happening?

H stands for **How**, which follows the Ws.

Fundraising

In planning any fundraising consider:

- What do you need the money for, and how much? Do a budget.
- When will you need it? Produce a Time Line.
- What will you do if you can't raise the total you need?
- Who is likely to fund you, and why should they support you?
- Will you need more money later when initial funds are used up?

Governance

Governance is the issue of 'who is in charge — ultimately'. In an organisation or company it is clearly the management committee or Board. Governance and accountability is less clear in a network, which may raise concerns if the network is dealing with public funds and community concerns. This may be dealt with by transparency, community involvement and participation.

Joining up

Increasingly partnerships are formed to 'join up' the activities of different agencies. Government is a strong advocate of 'joined up thinking'. The test of effectiveness is whether a partnership can go beyond joined up writing (of bids) through joined up talking and thinking to joined up delivery. See projects and teams.

Launch

A launch can be useful both externally internally:

- It provides a formal start line if used at the beginning, when you can outline the overall process and your stance to others.
- It is a good time to attract media coverage.
- It is an opportunity for social contacts.
- It is a deadline for making decisions and preparing materials.

Legal advice

Consult a solicitor if you are forming a company and/or seeking charitable status. However, do choose one who specialises in this field... it can be a false economy to take 'free' advice.

Management committee

The management committee is the governing body for an organisation, to which staff are accountable. In a company it is the Board of directors. It is important to strike a balance in composition: little will be achieved if everyone on the committee has to learn how to manage an organisation. However, a committee which has no representation of key interests may well find itself in difficulty. Networks may operate as 'self governing' groups, in which case community involvement and participation will be particularly important.

Media

News is what somebody somewhere wants to suppress; all the rest is advertising. Lord Northcliffe.

The media is mainly in the business of interesting and entertaining its users, and of selling itself or advertising. It is not there as a public service to promote your ideas or project. Journalists judge what is news against 'news values' which generally include:

- Conflict (where's the row).
- Hardship (how many hurt, who is in danger).
- Oddity (that's unusual).
- Scandal (sex, corruption).
- Individuality (what an interesting person).
- Disclosure (we can reveal).

Local journalists have a more relaxed view than Lord Northcliffe, but you do need to consider what's in the story for them. In producing a press release, make sure you have answered the Five Ws plus H.

Meetings

Meetings are at the heart of partnership building processes, whether social get-togethers, committees, workshops, or public meetings.

Meetings checklist

For effective meetings, consider:

- Style of the meeting. If it is to be a creative workshop rather than a committee, make sure people know that in advance.
- An accessible venue (public transport, disabled access).
- Child care (crèche, financial assistance).
- What information and notice is appropriate beforehand. Provide papers with options for formal meetings, but only an outline for a workshop so that people are spontaneous.
- Any aids you will need: charts, projectors etc.
- The layout of the room, and scope for breaking into small groups. Avoid a platform and lecture-style seating
- Good management of the meeting itself, and follow-up: see Action plans, Committees, Public meetings, Workshops.

Membership

Partnership organisations may have wide (public) or limited membership, which may or may not have rights to elect the management committee or Board. If you do plan a membership, consider what benefits you will offer and the costs of providing any services.

Money

Any partnership undertaking substantial work has to consider whose bank account holds funds, and who can sign the cheques. This consideration, more than any other, is likely to determine the structure of a partnership. The account could be with an existing organisation, or that of a new partnership company. 'Networky' partnerships may be able to manage by different team using different organisations as fund holders.

Networks

We are all members of networks — of friends, family, work, acquaintance, hobbies — and communities can be seen a lots of

interlinked networks. Online communication makes it much easier to develop and sustain networks, and richness of connections they offer. Because of this, partnerships are becoming more 'networky'. Networks place more emphasis on connections between individuals than partnerships formed by bringing different groups or organisations together. One model for a 'networky' partnership is linked project teams.

Networking

Networking is the important business of making informal contacts, chatting, and picking up further contacts. It is the way to learn:

- What issues people consider important.
- The sort of ideas and language they find familiar.
- Who are the key people and organisations — the stakeholders.

Networking is important before other more formal information-giving like producing leaflets, staging exhibitions and holding meetings. National networking organisations may also be able to provide you with local contacts, and similar projects elsewhere. Online communication has added another dimension to networking because it is possible to keep in touch more easily and cheaply.

Not invented here

The opposite of ownership, and one of the most significant barriers to participation and partnership. People are far more likely to participate effectively in partnerships if they play a part in developing ideas and action plans. Networks may enable people to maintain their own territories - but still require some shared commitment.

Online

Online is where you are when you are connected to the Internet.... a global network of computers enabling you to use email, World Wide Web and other tools increasingly essential to partnerships. See email, WWW , virtual teams and networks for why. The UK Government has set targets for all citizen dealings with Government to be online by 2005. That means all inter-organisational dealing are likely to be online too. If you are not online, you will be out of the loop.

Outcomes

Outcomes is used here to describe those general results of plans and actions which you are seeking to achieve. Thinking in terms of outcomes which you may see, hear, feel as well as the more abstract aims and objectives should help clarify what to do to achieve what you want. For partnerships to work well, the outcomes sought by different parties must dovetail to some extent.

Outputs

Outputs are the measurable results of projects or programmes — homes built, people who have completed training — and are dear to funders who want to know what they are getting for their money.

Ownership

The more you let yourself do, the less others let you do. Friedrich Nietzsche.

The stake that people have in an idea, a project or an organisation is fundamental to their commitment. For that reason, early brainstorming workshops, where everyone has a chance to contribute ideas, are important.

See also Control.

Participation

Participation is used here to describe a process by which individuals, groups and organisations are consulted about or have the opportunity to become actively involved in a project or programme of activity.

Partnership

All animals are equal, but some animals are more equal than others. George Orwell.

Partnerships are formal or informal arrangements to work together to some joint purpose. In my view:

- Informal partnerships work best when the project is specific and clearly achievable.
- Where the task is complex and long term it may be necessary to create a more formal structure for decision-making .
- It is difficult to tackle a wide range of issues through an informal partnership. It is better to treat this as consultation,

or form a network where different groups tackle different projects.

- Simply setting up a partnership structure doesn't solve the problems. You still need to clarify joint purpose, values etc.

Partnerships do not have to be equal — but the various parties do need to feel that they are involved to an appropriate degree.

Partnership building

Partnerships, like relationships, take time to develop. Are partners after the same thing (outcome)? Do they have the same idea of what is important (values)? Do they trust each other? It may be helpful to think of developing a partnership as a four-stage process:

- Initiation: something triggers the idea of a partnership.
- Preparation: the initiator plans how to involve others.
- Action: the partnership is formed.
- Continuation — or separation.

Post-it notes

A great technical aid to collective decision-making, and an improvement on basic Brainstorming. When running workshops give people pads of Post-its to write their ideas on, then stick them on a chart and move them around into groups.

Power

Issues of power and control are central to the development of partnerships. For example:

- Do all key interests have an equal ability or opportunity to participate in developing in the partnership if they wish?
- Who designs the partnership building process; to whom are they accountable?
- Who sets the timetable and controls the funds?
- Who makes the final decisions?

The rhetoric of partnership can often be used to

disempower people if it is used - consciously or unconsciously - to mask these fundamental questions. Partnerships should aim to increase the 'power to' of partners while avoiding imbalances of 'power over' that are unacceptable to some partners.

Practitioner

Used here to mean paid workers involved in local organisations and/or projects for community benefit.

Priorities

One effective means of clarifying the purpose and values of a partnership is to brainstorm project ideas, and then as a group to prioritise what is most important, and what has to be done first.

Private sector

Businesses, large or small, are as much part of any community as local residents and are key partners for partnerships like Development Trusts for several reasons:

- Trusts need business skills among both staff and Board members.
- Companies may be able to offer help in kind of premises, equipment and staff time. Occasionally they may offer funding.
- The private sector will be an important partner in developing Trust projects and programmes.
- In the long term local businesses are the key to local prosperity and a healthy local economy.

Public meetings

It is a general error to imagine the loudest complainers for the public to be the most anxious for its welfare. Edward Burke.

Although widely used, public meetings are not the most effective method of involving people. While they may be useful giving information, and gaining support around a clear-cut issue, they are poor vehicles for debate and decision-making. Classic public meetings with a platform party can easily be dominated by a small number of people, and become stage sets for confrontation.

Checklist

If you do hold a public meeting:

- Ensure good preparation and publicity.
- Research and focus on local concerns.
- Keep any presentations short with opportunities for response.
- Consider breaking into small groups for some of the time.
- Choose someone independent and locally respected as chair.
- Ensure the venue is easily accessible.
- Build on the results and report back on progress.
- Make a public meeting the last thing you do in a process - not the first - after networking and workshops.

Process

The creation of a partnership should be seen as a partnership building process — not simply formalisation of a structure. During that process partners have to work on a multitude of practical tasks, and also develop trust in each other and a shared style of operation.

Projects

Projects are what partnership do in order to achieve their desired outcomes. In order to turn the statements of purpose into reality, concentrate on developing projects ideas, prioritising and forming teams to carry them out.

Purpose

'If one does not know to which port one is steering, no wind is favourable.' Seneca.

A statement of purpose is a summary in a sentence or two of your intention — your aims and objectives. Statements of purpose may start out as broad intentions like 'we aim to create a better place to live and work'. They become meaningful when the aim is followed with statements of how: for example 'by

providing advise and support for practical environmental projects'. There may be a number of these 'how to' statements which are objectives. If they are measurable, they become targets.

See also Aims and objectives, Outcomes, Vision.

Representation

The conventional way to address accountability is to elect or appoint people from different interest groups to the partnership or other structure. This may not be appropriate where the focus is on delivering a number of short-term projects through a network approach. Instead aim for community involvement to ensure those interested have a say and/or play a part.

Rhetoric

Unfortunately there is often an inverse relationship between the extent to which organisations say they want to work in partnership, and the extent to which they practice what they preach. In order to challenge an excess of rhetoric, ask exactly how interested parties can participate. Is there any shared control? Does power to act lie with only one partner? Who benefits? One advantage of a constitution is that it makes these issues explicit.

Scope

Partnership consultant Drew Mackie offers the acronym SCOPE as a way of summarising criteria for choosing a structure

Sustainability: will any initiative be able to keep going long enough to do the job.

Clarity: is it evident to all just who is doing what and why.

Purpose: is that clear, and does it have general support.

Ownership: will any new arrangements command the support of communities, local organisations and the agencies.

Effectiveness: will the new arrangement get the job

done.

Use **SCOPE** to review any proposed structure.

Small groups

Large meetings and committees are usually unsatisfactory for working through difficult issues. Take some time to break into groups and report back. Keep the group between 3 and seven or eight in size. Avoid formal group leadership...encourage all to participate, with someone recording ideas on a chart.

Socials

Among the committee meetings and workshop sessions allow time for social events where people can get to know each informally. Celebrate success, keep each other cheerful during tough times.

Stakeholders

Stakeholders are those with an interest, because they will be affected or may have some influence.

Stakeholder analysis

In order to think through the role of stakeholders:

- Consider who the key stakeholders are.
- Put yourself in their shoes: how are they likely to react ?

Steering committee

Steering committees are groups, often with wide representation, responsible for the direction of a project. In order to ensure all parties play a part:

- Clarify accountability and terms of reference.
- Run some sessions as workshops, rather than formal committee meetings, and develop agreed action plans.

Consider whether you need a committee to 'steer' others - or whether to go for a flatter self-governing structure. If you want to bring in more people, they

may be better seen as advisors.

Structures

Successful partnerships are not created solely by choosing the right structure, any more than marriages are made just by marriage vows. Partnerships should be founded on a clear purpose, trust, and appropriate projects — and that takes a partnership-building process over time. If you are planning a big programme where a number of interests want a real stake over a long period, go for a company. If you are planning a number of short term projects, consider working through an existing organisation. Bear in mind

- Whoever holds the cheque book controls the project or programme. Should this power to lie with an existing organisation, a new one - or several project-related groups?
- Staff will ultimately follow the directions of whoever pays their wages.
- Information is power, and whoever produces papers, agendas and writes the minutes controls formal meetings. Reduce this problem by running workshops with independent facilitators, followed by more formal decision-making

The acronym SCOPE (sustainability, clarity, ownership, purpose, effectiveness) should help you make a choice on structure.

Style

How things are done can be as important as what is done in partnerships. Are operations transparent, or do things seem to be run by cliques? Are meetings formal committee style, or is there a flip chart in the room (and used)? Being open doesn't mean being ineffective... but nor does 'everyone must have a say' achieve results. Strike a balance.

Sustainability

Forming a partnership may not be easy — but keeping it going may be tougher. For that reason Development Trusts, and other formal partnerships that employ staff, properly put a lot of emphasis on business planning

and creating an asset base. In order to achieve their social objectives they need first to create a viable non-profit business. There is, of course, a danger that the desire for a sustainability overshadows the original purpose.... and the partnership expands its activities simple to stay in business. In some circumstance it may be more appropriate to plan for a time-limited initiative working through existing organisations.

SWOT

SWOT stands for Strengths, Weaknesses, Opportunities and Threats. It's a good technique to start planning a partnership.

Using SWOT

When you are clear what your aim is:

- 1 Brainstorm issues under each heading. Strengths and weaknesses relate to internal matters for the group or organisation, opportunities and threats to the external. Divide up a chart, and ask people to fill in and stick on Post-it notes.
- 2 Draw up a summary and discuss how to build on your strengths, do something about your weaknesses, make the most of the opportunities, avoid or eliminate the threats.
- 3 Turn these conclusions into project ideas and prioritise for an Action plan.

Synergy

One of the main reasons for a partnership is to make $2 + 2 = 5$. This may come by getting more funds or other resources than partners can alone; matching skills; or creating innovative ways of looking at problems.

Take stock

At the start of a partnership-building process take stock by carrying out a SWOT analysis, identifying stakeholders and clarifying your aims and objectives.

Team building

Team building is the process of helping a group develop shared aims and objectives, values and a plan to put them into action. People working together are better able to get to know each other than, for example, members of a management committee meeting every month or two — so team-building workshops can be particularly important for partnerships. I suggest, if possible, bringing in a trainer who specialises in team building to plan a programme. If not, an 'away day' with a facilitator to work on simple techniques like Brainstorming and SWOT can achieve a lot.

Teams

Instead of creating lots of sub committees, consider setting up project teams with a mix of appropriate skills and a team leader to chase progress. If the teams include people from different organisations or groups, and then network together, you have a 'flat' partnership. Someone has to coordinate — but that can be done by running workshops and online discussion with team leaders.

Terms of reference

Any committee, group or team needs clear terms of reference covering:

- The purpose and membership of the group.
- Who services it.
- How often it meets — and for how long.
- The topics or issues the group covers.
- The powers of the group to make decisions.
- What funding it has, if any

The outcomes expected.

- To whom it reports.

Timeline

It takes time to save time. Joe Taylor.

Everything takes longer than you think — even when

you know it does. Drawing a timeline is a simple technique to set priorities among activities and events that must be completed in creating a partnership or carrying out programme.

- Draw a horizontal line on a piece of paper.
- Graduate it into appropriate blocks of time (days, weeks, months). The first mark is NOW, the last the completion date.
- Think of all the tasks to be completed.
- Place the tasks on the time line in the order of when they have to be done, and which are the most important to do at a particular time.

Trading company

Charities cannot engage in income-generating trading unless it is pursuit of their objectives. They can, however, set up subsidiary trading companies which covenant profits back to the charity. If you are considering this type of arrangement consult a solicitor and an accountant experienced in the field. While the option may appear attractive, many charities have found trading companies problematic. Unless well run, they can cost more than they earn.

Transparency

If partnerships and networks are using public money and/or aiming to work in the public interest, their activities should be open to scrutiny... they should be transparent except where matters are necessarily confidential. This may be achieved through planned community involvement and participation. The move towards online communication will increase demands for transparency because it is so easy to disseminate information through email and Web sites.

Trust - confidence

Trust is an essential foundation for all aspects of participation and partnership. It comes from working together and through that discovering shared values and ways of doing things. In order to develop trust:

- Draw out and deal with any suspicions from past

contacts.

- Be open and honest about what you are trying to achieve — and about any problems.
- Be prepared to make mistakes — and admit them.
- Meet people informally.
- Deliver what you promise.

Trust — holding in trust

Trust is a term rather loosely used for different types of organisations. When lawyers use 'Trust' they may mean a legal arrangement created through a Trust deed in which trustees are bound to use funds provided by a benefactor to assist beneficiaries. Trust is also used in the title of various partnership organisations like Development Trusts and community trusts. Here it does not have a strict legal meaning, but usually implies that the organisation is a charitable company or has charitable purposes.

Trustees

If a Development Trust or other partnership is a charitable company, the Board of directors will also be trustees - that is, they will have responsibilities under the Charities Acts as well under company law. These responsibilities are wide ranging, and trustees should be well briefed and offered training in their role.

Values

In any assembly the simplest way to stop the transaction of business and split the ranks is to appeal to a principle, Jaques Barzun.

Values are statements of what we consider important. Since they may be emotive, political, and difficult to express, they are frequently hidden. However it is difficult to understand each other or reach agreement if we are unclear about values. For example, council officers faced with a tight project timetable may be frustrated by a community group which insists on numerous meetings, held in the evenings, leading to the appointment of a representative steering group. The officers value cost-effective delivery of 'product' acceptable to their political masters and the

Government; the group values openness and democratic process. In groups where there may be underlying differences of values it is often most productive to concentrate first on what there is in common by discussing outcomes — what you would like to happen at the end of the day — and how you can get there.

Vision

You see things; and you say 'Why?' But I dream things that never were, and I say 'Why not?' George Bernard Shaw

The idea of a vision of the future seems to me rather broader than purpose , because it places more emphasis on values and approach — how you do things as well as the result you achieve. Vision may be a helpful term if you are using participation techniques that encourage people to create pictures of what they want, or develop models. Partnerships need vision — and visions.

Virtual teams

Once people are online it is possible to form virtual teams — that is, groups who work together through the use of email and other Internet tools as well as phone and face to face.

Workshops

Workshops are meetings at which a small group, perhaps aided by a facilitator, explore issues, develop ideas and make decisions. They are the less formal and creative counterpart to public meetings and committees.

See also Brainstorming, Charts, Post-it notes, Small groups.

WWW

WWW = World Wide Web, which is the means by which pages of text, pictures, sound, video can be displayed anywhere in the World using the Internet. The Web means that even small organisations can have a presence online. Increasingly, organisations will be expected to use the Web to make all key information available to their client groups, thereby increasing their

transparency.

Collaborations and Partnerships

Sources for Information:

Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey, by Michael Winer and Karen Ray, Amherst H. Wilder Foundation, St. Paul, MN, 1996.

Meeting the Collaboration Challenge Workbook, The Peter Drucker Foundation for Nonprofit Management, New York, NY, 2002.

The Collaboration Challenge: How Nonprofits and Businesses Succeed Through Strategic Alliances, by James E. Austin, The Peter Drucker Foundation for Nonprofit Management, New York, NY, 2000.

National Institute of Justice Centers for Disease Control and Prevention Research in Brief, Public Health/Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs, and TB, US Department of Justice – Office of Justice Program, July 1998.

Building Coalitions

<http://ohioline.osu.edu/lines/kids.html#COALI>

National Network for Collaboration Manual

<http://crs.uvm.edu/ncco/cd/tablecon.htm>

Evaluation Tools

<http://crs.uvm.edu/ncco/cd/tools.htm>

Research – Building and Maintaining Community Coalitions on Behalf of Children, Youth, and Families – Parts 1-3.

Community-Based Collaboration: Community Wellness Multiplied

<http://crs.uvm.edu/ncco/collab/wellness.html>

University of Wisconsin – Extension Program Development and Evaluation

<http://www.uwex.edu/ces/pdande>

Reporting

http://www.uwex.edu/ces/pdande/evaluation/pdf/G3658_132.pdf

Quick Tips

<http://www.uwex.edu/ces/pdande/resources/index.html>

Evaluating Collaboratives: Reaching the Potential

July 1998

Kentucky Division of Substance Abuse and REACH of Louisville – Prevention Evaluation Perspectives – Community Coalitions, Vol. 1, Issue 1, Fall 2003

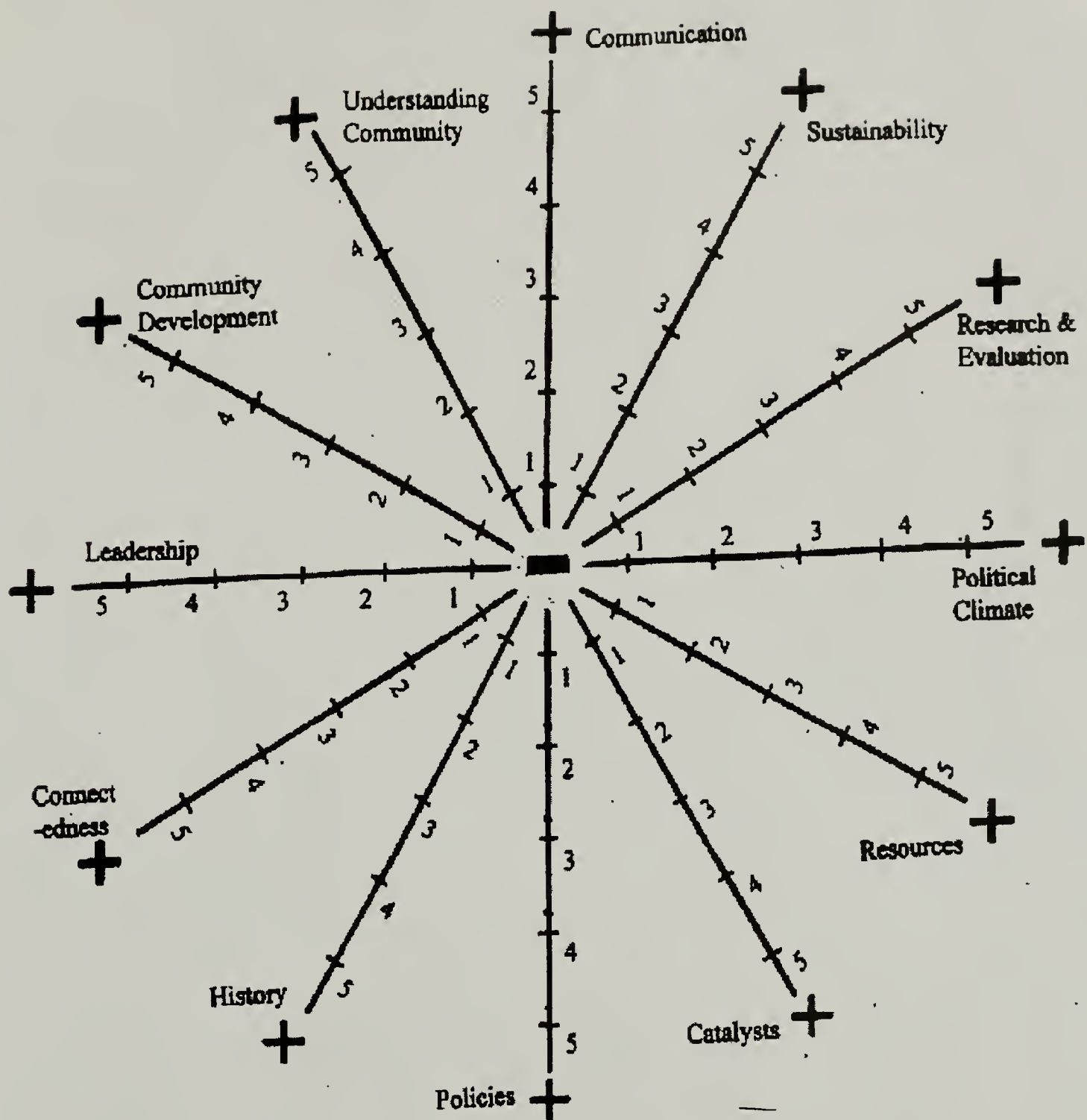
Examples of Collaborative Efforts

Healthy Children Organizing Project (San Francisco)

<http://www.consumer-action.org/English/hcop/index.php>

Center for Collaborative Planning

<http://www.connectccp.org/programs/index.shtml>



Factors Influencing Collaborations
National Network of Collaborations

